STATE OF IDAHO

PROVIDER AGREEMENT

Between

THE DEPARTMENT OF HEALTH AND WELFARE

and

_____

A VALUE CARE ORGANIZATION

THIS AGREEMENT FOR FURNISHING SERVICES UNDER THE HEALTHY CONNECTIONS VALUE CARE PROGRAM AS A VALUE CARE ORGANIZATION ("Agreement") is by and between the **IDAHO DEPARTMENT OF HEALTH AND WELFARE** ("the Department"), and _____ ("Value Care Organization or VCO"), each a "Party" or collectively, the "Parties."

WHEREAS, the Department desires to establish the Healthy Connections Value Care Program to reduce the overall cost of care in Medicaid while advancing preventive care and promoting better health outcomes;

WHEREAS, the Department was granted authority by the Idaho legislature to enter into agreements with providers that are paid based on healthcare quality and positive impacts to participant health, which was codified at Idaho Code § 56-265(5);

WHEREAS, the terms of this Agreement and Idaho's State Plan Amendment are subject to review and approval by the Centers for Medicare and Medicaid Services ("CMS") whose approval is necessary to allow Value Care Organizations (VCO) to coordinate the delivery of health care services pursuant to Section 1905(t) of the Social Security Act;

WHEREAS, VCO is a legal business entity operating as either a healthcare provider, a healthcare facility or a network of healthcare providers and/or healthcare facilities who is or whose Network Providers are authorized by Medicaid to provide covered services to Participants;

WHEREAS, VCO desires to collaborate with the Department to improve the quality of care, reduce healthcare costs and achieve the program goals stated below;

WHEREAS, based on the above-cited authorities, the Department intends to contract with VCO to achieve the following Program goals:

- Triple-aim of better care for patients, better health for communities and lower costs;
- Patient-centered care that is highly coordinated;
- Local governance by those who deliver care;
- Payment methodologies that reward accountability, quality, efficiency and access;
- Low administrative costs; and
- Community involvement through advisory groups and support for community initiatives that advance population health;

WHEREAS, VCO agrees to participate in the Value Based Incentive Payment model measuring VCO's performance in managing Attributed Participants using several quality and cost metrics, attached hereto; and

WHEREAS, the Department contemplates, pursuant to its statutory mandate, that its policies will permit VCOs, and participating providers within the VCOs, to engage in cooperative and interactive conduct that will, at times, displace competition in the provision of healthcare

services, the Department shall exercise ultimate control over the services provided pursuant to the express terms of this Agreement and active Department supervision and review;

NOW, THEREFORE, in consideration of the mutual covenants, representations and warranties contained herein, the Parties agree as follows:

Article I

1. Definitions. As used in this Agreement, the following terms shall have the meanings set forth below:

1.1 Assignment/Assigned. The process by which Medicaid Participants choose or are assigned by the Department to a Healthy Connections Service Locations for purpose of managing and coordinating their health care.

1.2 Attribution/Attributed. The process of attributing Participants to a VCO for purposes of calculating the Total Cost of Care. The Attribution process is further described in Exhibit 1D hereto.

1.3. Department. State of Idaho, Department of Health & Welfare, its divisions, sections, offices, units, or other subdivisions, and its officers, employees, and agents.

1.4 Healthy Connections Program. A Medicaid program charging Primary Care Providers with the task of managing and coordinating the delivery of all care provided to Participants Assigned to them with the goal of improving quality, controlling the cost, and improving the outcome of the care. Participation in the Healthy Connections Program requires providers to sign a Healthy Connections Coordinated Care Provider Agreement.

1.5 Healthy Connections Value Care Program ("Program"). A program designed to incentivize VCOs to improve the quality and to control the cost of care provided to Participants. The Program includes a Value Based Incentive Payment model for rewarding improvements and accountability for lack of improvement.

1.6 Healthy Connections Service Location. A medical clinic at one location consisting of at least one Primary Care Provider who is a Medicaid Participating Provider and has an active Healthy Connections Coordinated Care Provider Agreement. A Healthy Connections Service Location may only participate in one VCO at a time. A healthcare provider organization with more than one Healthy Connections Service Location may only participate with one VCO at a time, and all its Healthy Connections Service Locations must participate in the Program, unless an exception is granted by the Department.

1.7 **Medicaid**. A program administered by the Idaho Department of Health and Welfare for providing health care coverage to qualifying Participants. Participation in the Medicaid Program requires providers to have a Medicaid Provider Agreement.

1.8 **Participant.** A person receiving Medicaid benefits, enrolled in the Healthy Connections Program, and not excluded from this Program as defined in Exhibit 1D.

1.9 **Performance Year.** The twelve-month period used in the Value Based Incentive Payment model as the period of time for evaluating VCO performance and calculating the Total Cost of Care.

1.10 **Primary Care Provider ("PCP").** A VCO Network Provider whose area of practice and training is family medicine, internal medicine, obstetrics/gynecology or pediatrics, as well as other affiliated providers including nurse practitioners, physician assistants and certified nurse mid-wives, who has agreed to provide primary care services and to coordinate and manage care. Each PCP must operate under an active Healthy Connections Coordinated Care Provider Agreement.

1.11 **Provider Handbook.** The Medicaid Provider Handbook, as amended, and any instructions contained in provider information releases or other program notices. The Provider Handbook is available to all providers enrolled in Medicaid and is intended to provide basic program guidelines; however, in any case where the guidelines appear to contradict relevant provisions of Idaho Code or rules, the code, or rules prevail.

1.12 **Quality Performance Program.** A component of the Value Based Incentive Payment model, as described in Exhibit 1C, for measuring and evaluating the VCO's performance in improving the quality of care provided to Participants Attributed to the VCO.

1.13 **Total Cost of Care (TCOC).** A component of the Value Based Incentive Payment model, as described in Exhibit 1 Article III, for measuring and evaluating the VCO's performance in controlling the cost of care provided to Participants Attributed to the VCO.

1.14 **Value Based Incentive Payment.** A risk arrangement, as described in Exhibit 1, incorporating the Quality Performance Program and the TCOC calculation for purposes of incentivizing the VCO to control the costs and improve the quality of care provided to Participants Attributed to the VCO.

1.15 **Value Care Organization ("VCO").** A legal business entity such as a large medical group, an association of medical groups, a hospital system, an organization consisting of a collaboration of independent medical groups or a provider network such as an Independent Practice Association (IPA) or Physician Hospital Organization (PHO), whose network of health care providers include at a

minimum a panel of PCPs large enough to meet the Program requirement stated herein. Participating hospital systems must, unless an exception is granted by the Department, include in the VCO all its acute care hospital locations and Healthy Connection Services Locations within the VCOs service area.

1.16 VCO Network. The network of healthcare providers affiliated with the VCO as defined below, and who have agreed to participate in the Program through the VCO. A VCO Network must include at a minimum a panel of Primary Care Providers contracted with the Healthy Connections Program as outlined in Exhibit 1 Article II and may include other types of VCO Network Providers.

1.17 VCO Network Provider. Any licensed health care provider, group of providers, hospital, ancillary provider, or other provider entity affiliated with the VCO through employment or contract. A VCO Network Provider must have an active Medicaid Provider Agreement.

Article II

2.0 VCO Minimum Requirements.

2.1 Legal Business Entity. VCO shall be a legal business entity established in its state of operation with an organizational structure capable of performing the duties and obligations of the VCO as described herein.

2.2 Provider Panel. VCO Network must include at a minimum a panel of qualifying Primary Care Providers large enough to fulfill the duties and obligation of the VCO as described herein and any additional requirements listed in Exhibit 1 Article II.

2.3 Minimum Participant Assignment. To participate in the Program, a VCO's participating Healthy Connections Service Locations must have a combined total of at least two thousand (2,000) Participants Assigned to its VCO Network.

2.4 Healthy Connections Service Location. VCO must provide a roster of the Healthy Connections Service Locations participating in the Program through the VCO to the Department ninety (90) days prior to the effective date of the first Performance Year unless an exception is granted by the Department.

2.4.1 For each Performance Year thereafter, the VCO's may change the Healthy Connections Service Locations participating with the VCO. Notice of such changes must be received by the Department one hundred and twenty (120) days prior to the effective date of the Performance Year.

2.4.2 Any changes in participating Healthy Connections Service Locations during a Performance Year must be approved by the Department.

2.5 **Value Based Incentive Payment**. As part of this Agreement, the VCO must participate in a Value Based Incentive Payment risk arrangement, terms of which are defined in Exhibit 1.

Article III

3.0 **Participant Attribution Methodology.** The Value Based Incentive Payment risk arrangement will measure and evaluate the VCO's performance in controlling the costs and improving the quality of care provided to Participants Attributed to the VCO. Participants will be Attributed to the VCO according to the methodology set forth in Exhibit 1D.

Article IV

4.0 **Advisory Committees**.

4.1 **Statewide Care Collaborative (SCC).** An SCC will be established by the Department as a venue for the Department and the VCOs to monitor and evaluate the performance of the Program in meeting its goals and objectives. The SCC will also provide a forum for raising concerns and recommending solutions regarding issues that may arise in the delivery of healthcare to Participants. SCC participation will include representatives of the Department and representatives of each contracted VCO in the state. The Department may, at its discretion, include representatives from other contracted healthcare entities. The Department with input from the VCOs will facilitate meetings, manage agendas, and establish topics for discussion. The SCC will meet, at a minimum, on a quarterly basis with at least one in-person meeting annually.

Article V

5.0 **Duties of VCO.**

5.1 **Operational Activities.** VCO shall possess expertise as outlined in this Article V and comply with the operational requirements established in this Agreement. VCO shall comply with reasonable requests by the Department to audit VCO's records and/or processes to ensure that VCO's operations remain in compliance with this Agreement.

5.2 **Clinical Activities.** VCO shall maintain an organizational structure and programs designed to improve and integrate systems of care delivery and coordination

between providers, promote evidence-based care and yield improved clinical outcomes.

5.3 **Data Management.** VCO shall comply with reasonable requests from the Department for data and information necessary for the Department to fulfill its duties and obligations under this Agreement. These terms and conditions shall be set forth in the Data Use Agreement, with the current version attached and subject to revision upon mutual written agreement of the Parties.

5.4 **VCO Network Management.** VCO shall develop clinical and operational processes to enhance the performance of the VCO Network in achieving the quality, cost and outcomes goals and objectives of the Program including the following tasks:

5.4.1 Communicate to VCO Network Providers the goals and objective of the Program and their duties and responsibilities. Educate VCO Network Providers on VCO's clinical and operational processes (the "clinical model").

5.4.2 Monitor VCO Network Providers in the execution of VCO's clinical model and hold them accountable for the goals and objectives of the Program, including improving quality and outcomes and reducing costs. VCO shall develop a process for rewarding clinical improvement and holding those accountable for lack of improvement.

5.5 **VCO Network Provider Obligations.** VCO will ensure VCO Network Providers are contractually obligated to comply with the terms of this Agreement. VCO shall notify the Department of any requirements in the participation agreement between the VCO and VCO network Providers that conflicts with either this Agreement or the Healthy Connections Coordinated Care Agreement. The parties agree to use best efforts to resolve the conflict.

5.6 **VCO Changes to Policies and Procedures.** In coordination with the VCO's clinical model, the VCO may, with the prior written approval of the Department, modify current Medicaid or Healthy Connections Program policies and procedures. VCO modifications may require the VCO to assume additional responsibilities and duties which would be listed in an addendum to this Agreement.

5.7 **Advisory Committee Participation.** VCO will designate representatives to serve as participants of the applicable SCC Committees.

5.8 **Participant Information.** VCO must make available to Participants, upon request, information regarding VCO's participation in the Program. At a minimum, this information must:

- be pre-approved by the Department;
- include a high-level overview of the VCO's program; and
- include the impact on the Participant's care, if any, because of the VCO participation in the Program.

5.9 **VCO Reporting to the Department**. VCO shall report to Department or make available for the Department's inspection data and information sufficient for monitoring quality and cost performance including any data needed to complete the calculation of the Value Based Incentive Payment Program. The terms and conditions of the VCO's reporting requirements will be set forth in the Data Use Agreement, as reflected in Exhibit 2, and mutually agreed to by the Parties. Data and information provided to the Department will be held in confidence in accordance with the terms in Section 9.14.

5.10 **VCO Reporting to VCO Network Providers.** VCO shall be responsible for reporting to VCO Network Providers the annual results of the Value Based Incentive Payment. The distribution or recovery of funds shall be in accordance with the VCO's internal process.

5.11 **Participant Grievances.** VCO will cooperate with the Department in responding to grievances filed by Participants with the Department, including appearing at fair hearings as reasonably requested by the Department.

Article VI

6.0 Quality Measures.

6.1 The quality measure, benchmarks, methods and formulas (the "Quality Performance Program") used to evaluate VCO's performance are defined in Exhibit 1C.

6.2 Department will meaningfully engage VCOs and applicable stakeholders in reviewing and making recommendations for annual modifications to the Quality Performance Program.

6.3 Department shall notify VCO at least one hundred eighty (180) days prior to the beginning of the period of its preliminary review of the quality measures and shall notify VCO at least one hundred twenty (120) days prior to the beginning of a Performance Year of any final changes to the quality measures.

Article VII

7.0 Duties of the Department.

7.1 **Medicaid and Healthy Connections Program.** The Department will continue to administer the Medicaid and the Healthy Connections Program under the current policies and procedures and may amend these policies and procedures in accordance with the provisions established by the department for those programs.

7.2 Department Reporting Obligations for each Performance Year. The Department shall provide to the VCO, at a minimum, the following reports with the description and method of communication set forth in a separate Data Use Agreement. The Department shall use best efforts to provide reports according to the timeline attached in Exhibit 2 and summarized below:

- Participant Enrollment Report
- Medical Claims Report
- Pharmacy Claims Report
- Baseline Participant Attribution Report
- Baseline MARA Risk Score Report
- Total Cost of Care (TCOC) Savings/Loss Report
- Quality Performance Program Report
- Gaps in Care Report
- Final Participant Attribution Report
- Final Quality Performance Program Report
- Final VCO TCOC Calculation Report
- Draft VCO Program Settlement Report

7.3 Advisory Groups. The Department will designate representatives to participate in the SCC Committees.

7.4 Grievances. The Department shall continue to administer its system to accept and respond to grievances filed by Participants pursuant to the Medicaid program policies and procedures.

7.5 Customer Service. The Department will continue to administer the Medicaid Program and Healthy Connections Program with respect to physical locations, phone centers and other contact methods allowing Participants to inquire about eligibility for benefits, claims payments and other Medicaid and Healthy Connections Program issues.

7.6 Notice of Proposed Changes. The Department will follow standard protocol including the Medicaid Newsletter as a means of communication to inform Medicaid Providers of any Medicaid or Healthy Connections Program changes. The Department will make best efforts to directly notify the VCO ninety (90) days prior to the effective date of any changes that may materially impact the VCO's performance in the Program.

Article VIII

8.0 Term, Renewal and Termination

8.1 Term of this Agreement. The term of this Agreement begins on the Effective Date identified on the Signature Page 15 of this Agreement and shall continue in

effect until December 31 and the end of the Performance Year. This Agreement shall renew automatically for renewal terms of one year, until terminated pursuant to the terms of this Article VIII.

8.2 **Termination Without Cause.** Either Party may terminate this Agreement without cause only at the end of each Performance Year. The terminating Party must provide written notice at least sixty (60) days prior to the end of the Performance Year. The Parties may not terminate this Agreement without cause with an effective date other than the end of a Performance Year.

8.3 **Immediate Termination.** Either party may terminate this Agreement immediately upon written notice if at any time:

8.3.1 Judicial interpretation of federal or state laws, regulations, or rules renders fulfillment of this Agreement infeasible or impossible;

8.3.2 VCO's license or certification required by law is suspended, not renewed, or is otherwise not in effect at the time service is provided; or

8.3.3 VCO, or a person with an ownership or controlling interest in VCO, is debarred, suspended, determined ineligible or excluded from participation in a government healthcare program.

8.4 **Termination for Cause.** Either Party may terminate for cause if the other Party is in default in the performance of any material obligation imposed under this Agreement including obligations to provide timely and compliant data and reports as set forth in the attached exhibits. If the default has not been substantially cured to the satisfaction of the non-defaulting party within thirty (30) days following receipt by the defaulting party of written notice of default, then the non-defaulting party may immediately terminate this agreement. The right of cure under this section shall not apply to a repeat default, defined as a circumstance in which the Party had received notice of default of the same material obligation.

8.5 **Termination for Material Change.** Either party may terminate this Agreement upon thirty (30) days' written notice in the event of a material change in law, policies, procedures, rate schedules, gross targets, actuarial assumptions used in setting the gross targets or other aspects of the Medicaid Program or the Value Care Program that has a substantial adverse impact on either party's ability to perform its obligations under this Agreement.

8.6 **Effect of Termination on Performance Year Settlement.** In the event there is an immediate termination, a termination for cause or a termination for material change during a Performance Year, the Department will complete a settlement of the Value Based Incentive Payment Program as described in Exhibit 1, Article II for the portion of the Performance Year prior to the effective date of the termination.

8.7 Continuing Duties in the Event of Termination. Upon termination of this Agreement, unless otherwise specified herein, the Parties are obligated to perform those duties which by their terms survive termination of this Agreement.

Article IX

9.0 Additional Requirements and Provisions

9.1 Audits. The Department, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the VCO, or its subcontractors related to participation in the Program. The right to audit under this section exists for five (5) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.

9.2 Assignment. Each Party's rights and obligations under this Agreement are personal and may not be transferred or assigned without the prior written consent of the other party. Any attempt at assignment or transfer without such consent shall be void. Any assignment or transfer of the either Party's rights and obligations approved by the other Party shall be subject to the provisions of this Agreement.

9.3 Records. The VCO shall maintain for a period of five (5) years books, records, and documents necessary (1) to demonstrate performance of obligations of this Agreement and (2) to certify the nature and cost of the services performed relevant to this Agreement. This Section shall not require the VCO to maintain records reflecting a VCO Network Provider's financial or clinical records.

If an audit, litigation, or other action involving records is initiated before the five (5) year period has expired, the VCO shall maintain records until all issues arising out of such actions are resolved.

9.4 Binding Effect of Federal Regulations and Idaho State Plan Amendment. This Agreement is subject to the provisions of any relevant federal regulations and any relevant provisions of agreements between the State of Idaho and the United States, including but not limited to State Plans, in effect at the time this Agreement is executed. Such regulations and agreements are on file in the Central Office of the Department and are available for inspection by the VCO during regular business hours.

9.5 Federal and State Audit Exceptions. If a federal or state audit indicates the VCO fails to comply with provisions of this agreement or applicable federal or state laws, rules, or regulations, the VCO shall refund and pay to the Department any compensation paid to VCO arising from such noncompliance, plus civil and monetary penalties as indicated.

9.6 **HIPAA.** The VCO acknowledges that it may have an obligation, independent of this Agreement, to comply with the Health Insurance Portability and Accountability Act (HIPAA), Sections 262 and 264 of Public Law 104-191, 42 USC Section 1320d, and federal regulations at 45 CFR Parts 160, 162 and 164. If applicable, the VCO shall comply with all amendments to the law and federal regulations made during the term of this Agreement.

9.7 **Lobbying.** The VCO certifies that none of the compensation under this Agreement has been paid or will be paid by or on behalf of the VCO to any person for influencing or attempting to influence an officer or employee of any governmental agency, a Participant, officer or employee of Congress or the Idaho Legislature in connection with the awarding, continuation, renewal, amendment, or modification of any contract, grant, loan, or cooperative agreement.

If any funds, other than funds provided by this Agreement, have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any governmental agency, a Participant, officer or employee of Congress or the State Legislature in connection with this Agreement, the VCO shall complete and submit Standard Form LL, "Disclosure Form to Report Lobbying," in accordance with its instructions, and submit a copy of such form to the Department.

9.8 **Dispute Resolution.** The Parties agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement prior to initiating legal proceedings. To the extent the Parties are unable to resolve the dispute through informal, good-faith negotiations, senior executives of both Parties shall meet in person to resolve the dispute. If further negotiations are unsuccessful, the Parties shall participate in non-binding mediation prior to initiating legal action.

9.9 **Qualification.** The VCO certifies to the best of its knowledge and belief that it and its principals:

Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from performing the terms of this Agreement by a government entity (federal, state or local);

Have not, within a three (3) year period preceding this Agreement, been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; or been convicted of criminal violation of federal or state antitrust statutes. Are not presently indicted for or otherwise criminally charged by a government entity (federal, state, or local) with commission of any of the above-stated offenses.

9.10 Faith-Based Organization. If any VCO Network Provider operates in accordance with specific ethical and religious directives that VCO Network Provider shall not be required to perform or otherwise participate in any service or procedure that are inconsistent with the medical ethics or precepts as defined in the applicable directives. At the request of the Department, the VCO Network Provider shall provide information on such directives.

9.11 Tribes. If the VCO is a Tribe, the VCO and Department recognize that services performed pursuant to this Agreement by the VCO and all approved subcontractors within reservation boundaries are subject to applicable laws, ordinances, and regulations of the Tribe. Nothing in this Agreement should be construed as a waiver of sovereign immunity.

9.12 Conflict of Interest. No official or employee of the Department and no other public official of the State of Idaho or the United States government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of this Agreement shall, prior to the termination of this Agreement, voluntarily acquire any personal interest, direct or indirect, in this Agreement or proposed Agreement.

The VCO covenants that it presently has no interest and shall not acquire any interest, direct or indirect, that would conflict in any manner or degree with the performance of its services hereunder. The VCO further covenants that in the performance of this Agreement, no person who has any such known interests shall be employed.

9.13 Confidentiality. Pursuant to Idaho Code section 74-101, *et seq*., information or documents received from the VCO may be open to public inspection and copying unless exempt from disclosure. If the parties agree that data or information required to monitor quality and cost performance or any other data or information includes confidential or proprietary information not generally known to the public, the VCO shall clearly designate individual documents as "exempt" on each page of such documents and shall indicate the basis for such exemption. The Department will not accept the marking of an entire document as exempt. In addition, the Department will not accept a legend or statement on one (1) page that all, or substantially all, of the document is exempt from disclosure. The VCO shall indemnify and defend the Department against all liability, claims, damages, losses, expenses, actions, attorney fees and suits whatsoever for honoring such a designation or for the VCO's failure to designate individual documents as exempt. The VCO's failure to designate as exempt any document or portion of a document that is released by the Department shall constitute a complete waiver of any and all claims for damages caused by any such release.

9.14 Headings. The captions and headings contained herein are for convenience and reference and are not intended to define or limit the scope of any provision of this Agreement.

9.15 Marketing. If VCO engages in Marketing, it must not use any marketing and or other activities which result in selective recruitment and enrollment of individuals with more favorable health status.

9.16 Indemnification. VCO shall indemnify, defend and save harmless the Department, its officers, agents and employees from and against any and all liability, claims, damages, losses, expenses, actions, attorney fees and suits whatsoever, caused by, arising out of, or relating to, the activities of the VCO or its officers, employees, subcontractors, or agents under this Agreement, or arising from the VCO, it's officers, employees, subcontractors, or agents' failure to comply with any applicable state, federal, local law, statute, rule, regulation or act. This duty to indemnify, defend and hold harmless, shall encompass any claims that include or allege negligence of the VCO, its agents, officers, or employees, other than claims which arise solely out of negligence on the part of the Department, and this duty shall survive the termination or expiration of this Agreement. Nothing in this provision shall extend VCO's indemnification of the Department beyond the liability of the Department provided in the Idaho Tort Claims Act, Idaho Code 6-901 et seq.

9.17 Sovereign Immunity. Nothing contained herein shall be deemed to constitute a waiver of the Department's sovereign immunity, which immunity is hereby expressly reserved.

9.18 Governing Law. This Agreement shall be governed by and construed under the laws of the State of Idaho and the Parties hereto consent to the jurisdiction of the state courts of Ada County in the State of Idaho in the event of any dispute with respect to this Agreement.

9.10 Notices. Any notice required to be given under this Agreement shall be in writing, electronic notice delivered in person, by public or private courier services (including U.S. Postal Service Express Mail), by certified mail with return receipted requested. All notices shall be addressed to the Parties at the notice addresses below or at such other addresses as the Parties may from time to time direct in writing.

Any notice shall be deemed to have been given on the earlier of: (a) actual delivery or refusal to accept delivery; or (b) the date of mailing by certified mail.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives upon the date written below.

DEPARTMENT:

By _____

Signature

Name _____

Print

Title _____

Date of Signature _____

VALUE CARE ORGANIZATION:

By _____

Signature

Name _____

Print

Title _____

Date of Signature _____

Effective Date of Agreement ___ 1/1/2024_____

Notice Address

_____

_____

Notice Address

_____

_____

Notice Attention

_____

Notice Attention

_____

Notice Email

_____

Notice Email

_____

Exhibit 1

Value Care Organization
Value Based Incentive Payment & Quality Performance

This Exhibit 1 sets forth additional terms for purposes of a Value Care Organization participating in the Value-Based Incentive Payment program; provided, however**,** in the event of a discrepancy or conflict between this Exhibit and the VCO Agreement, this Exhibit will take precedence.

Article I

The following terms are in addition to the terms defined in the VCO Agreement. As used in this Exhibit, the following terms shall have the meanings set forth below:

1.1 **Actual Cost - Program**: The sum of all Included Costs as defined in Exhibit 1B for Participants Assigned for at least seven months to the Healthy Connections Program based on the date of service during the Base Year, adjusted for Stop Loss as defined herein. In determining total Actual Costs for the Base Year, the Department will account for all claims incurred by Assigned participants during the period and paid during the period and the six months following the period allowing for a six-month runout.

1.2 **Actual Cost -VCO:** The sum of all Included Costs as defined in Exhibit 1B for Participants Attributed to the VCO incurred based on the date of service during each Performance Year, adjusted for Stop Loss as defined herein. In determining total Actual Cost for each Performance Year, the Department will account for all claims incurred during the period and paid during the period and the six months following the period allowing for a six-month runout. In the event a six-month run out period is insufficient due to a significant change in claims lag at the end of a Performance Year, the Parties will mutually agree on a method for applying an Incurred But Not Reported (IBNR) adjustment to the Actual Cost calculation.

1.3 **Actual Cost Per Member Per Month (PMPM):** The Actual Cost PMPM for the Base Year and each Performance Year shall be calculated by dividing the Actual Cost for the period by the number of Member Months for that period.

1.4 **Annual Program Change Factor:** The factor applied to the Base Year Standardized PMPM, used in setting the VCO Gross Target PMPM for the Performance Year.

1.5 **Base Year:** The base year will be the State Fiscal Year starting 2.5 years prior to the performance year, beginning July 1 and ending June 30.

1.6 **Base Year Risk Score:** The base year risk score is a calculation of a composite Risk Score by taking the final risk score for each Participant in the population multiplied by the

Participant's Member Months for the period, added together and divided by the total number of Participant Member Months with a risk score**.**

1.7 **Baseline Score:** VCO's "starting point" to determine the amount of improvement required for a quality measure score to qualify for an incentive payment. The Baseline Score will be the VCO's quality measure status as of June 30 of the Base Year with a 6-month run out period.

1.8 **Included Cost:** The expenses of Department for a Participant that will be counted in the calculation of Actual Cost, as set forth in Exhibit 1D.

1.9 **Incremental Annual Improvement Target:** The percentage of improvement required annually, per quality measure, to qualify for an incentive payment.

1.10 **Member Months**: The number of months within a Performance Year that a Participant is eligible and has been Attributed to the VCO. Additionally, it is the number of member months within the Base Year that a Participant is eligible and Assigned to the Healthy Connection Program. To qualify for either the Performance Year or the Base Year, a member must be Attributed or Assigned a minimum of seven months.

1.11 **Risk Score:** Risk Score is a composite score estimating the overall health risk of a population of Participants. The higher the Risk Score the higher the health risk of the population. Risk scores are calculated for each Participant each year using the Milliman MARA CXAdjuster Risk Scoring methodology. Risk Scores will be utilized by the Department to account for the differences in the severity of health risk between the Base Year and Performance Year population. In mathematical form, the calculation of a composite Risk Score is the final risk score for each Participant in the population multiplied by the Participant's Member Months for the period, all added together and divided by the total number of Participant Member Months with a risk score.

1.12 **Statewide Goal:** The Statewide Goal is set at the higher of the state average or the National 75th percentile. National Committee for Quality Assurance (NCQA) measures are set at the National-Health Maintenance Organizations (HMO) benchmarks. Non NCQA CMS Core Set benchmarks are set at the most recent Medicaid federal fiscal year reports available. Modified measures are set at the Base Year statewide average.

1.13 **Stop Loss:** For purposes of calculating Actual Cost, during the Base Year and each Performance Year, a stop-loss threshold shall apply to any Participant for whom annual aggregate Included Costs exceeds $100,000. Only twenty percent (20%) of the annual aggregate Included Costs for a Participant in excess of $100,000 and below $500,000 will be counted in determining the VCO's Actual Cost. By way of example, if the annual aggregate Included Costs for a Participant is $200,000 in a Performance Year, only $120,000 of those Included Costs will be included in the VCO's Actual Cost. No amount of annual aggregate Included Costs for a Participant in excess of $500,000 shall be included in the VCO's Actual Cost. By way of example, if a Participant's annual aggregate Included Cost is $600,000, only $180,000 (20% of $400,000 = $80,000 +

$100,000 = $180,000) shall be included in VCO's Actual Cost.

1.14 Statewide Risk Standardized PMPM: The calculation of Base Year Actual Costs PMPM divided by Base Year Healthy Connection Value Care Program Risk Score as defined in Article 3.3, or as negotiated by the Department and the VCOs in rare circumstances including, but not limited to, a public health emergency.

1.15 Total Cost of Care: The formula, as described in Article III, used to measure and evaluate the VCO's performance in controlling the cost of care provided to Attributed Participants.

1.16 VCO Gross Target: Gross Target shall be calculated by multiplying the Gross Target PMPM by the total Member Months Attributed to the VCO during the Performance Year.

1.17 VCO Gross Target PMPM: The per-member, per-month target established each Performance Year specific to the VCO. Gross Target PMPM is calculated based on the Statewide Risk Standardized PMPM in the Base Year, risk-adjusted, and trended forward as described in Article 3.3 and 3.5.

Article II

2.1 Requirements for VCO Participation. This Article II sets forth the requirements for **VCO** participation.

2.2 VCO Network. VCO must maintain a network of providers that includes at a minimum a Primary Care Provider (PCP) panel of Healthy Connections Service Locations that have combined a minimum of two thousand (2,000) Assigned Participants at the beginning of each Performance Year.

2.3 Satisfactory Assurance of Repayment. The Department may ask the VCO to demonstrate to the Department's satisfaction that VCO has sufficient financial resources to repay potential shared losses incurred through this Agreement.

2.4 VCO Savings Distribution. VCO shall document the amounts and its methodology for distributing shared savings and/or loss among VCO Network providers and shall make this information available to the Department upon request. The Department shall treat this information as proprietary and confidential as defined in Article 9.14 of the VCO Agreement.

2.5 VCO Selection of Quality Measures. Except as may otherwise be determined by the Department, the Quality Measures shall be selected by the VCO thirty (30) days prior to the start of each Performance Year. Mandatory quality measures and optional quality measures shall be set forth in Exhibit 1C Table 2.

2.6 VCO Selection of Level of Risk Sharing. Except as may otherwise be determined by the Department, the level of Risk Share shall be selected by the VCO thirty (30) days prior to

the start of each Performance Year. The risk sharing level selected by the VCO for the Performance Year shall be set forth in Exhibits 1A. The level of risk sharing selected must exceed the minimum yearly requirement set forth below.

Symmetrical savings and loss Risk Sharing options as stated below:

- Upside Only Gain Share Year 1 and 2 – 5%
- Minimum Risk Share Year 3 – 15%
- Minimum Risk Share Year 4 –25%
- Maximum Risk Share– 80%

2.7. Method of VCO Risk Level Selection. The Department will provide a fillable document to the VCOs to declare level of risk and select quality measures for the performance year. The Department will provide receipt of the risk declaration to the VCOs.

Article III

3.1 Total Cost of Care. This Article III sets forth the Total Cost of Care formula for determining the VCO's performance each year in controlling the cost of care provided to Attributed Participants.

3.2 VCO Performance. The VCO's individual performance for each Performance Year will be compared to the statewide PMPM adjusted for the VCO performance year risk score.

3.3 Statewide Risk Standardized PMPM. A Statewide Risk Standardized PMPM will be calculated based on the Healthy Connections Value Care Program performance during the Base Year as follows, or as negotiated by the Department and the VCOs in rare circumstances including, but not limited to, a public health emergency.

Base Year Actual Cost PMPM/Base Year Risk Score = Statewide Risk Standardized PMPM

3.4 Calculating the Statewide Annual Program Change Factor: A Statewide Annual Program Change Factor shall be set prospectively by taking the average of the PMPM change for three fiscal years preceding the Performance Year, or as negotiated by the Department and the VCOs.

3.5 VCO Gross Target PMPM. A Gross Target PMPM shall be calculated for each VCO as follows: (a) multiply the Statewide Risk Standardized PMPM from the Base Year by the Annual Program Change Factor(s); (b) multiply the result in (a) by the Performance Year VCO Risk Score. In mathematical form, the calculation is as follows:

Statewide Risk Standardized PMPM x Annual Program Change Factor x Performance Year VCO Risk Score = VCO Gross Target PMPM

3.6 **Performance Year Savings or Loss.** To determine the VCO's performance in controlling cost each Performance Year, the Department will compare the VCO Gross Target PMPM to the VCO's Actual Cost PMPM for the Performance Year to determine if the VCO has generated a savings or loss for the period. In mathematical form, the calculation is:

VCO Gross Target PMPM - Actual Cost VCO PMPM = Performance Year Savings (Loss) PMPM

3.7 **Gross Performance Year Savings or Loss**. Gross Performance Year Savings or Loss shall be calculated by multiplying the Performance Year Savings or Loss PMPM by total Member Months Attributed to the VCO during the Performance Year. Mathematically, the calculation would be:

Performance Year Savings (Loss) PMPM x Member Months = Gross Performance Year Savings (Loss)

Article IV

4.1 **VCO Distribution of Performance Year Savings.** This Article IV sets forth the methodology for determining the total distribution owed by Department to the VCO in the event of Performance Year Savings.

4.2 **Minimum Savings Threshold.** Gross Performance Year Savings must exceed one percent (1%) of the Gross Target to trigger Department's liability to VCO for any portion of Gross Performance Year Savings; provided, however, that if Gross Performance Year Savings exceeds the one percent (1%) threshold, all savings will be included in the calculation of Department's liability to VCO for a portion of Gross Performance Year Savings.

4.3 **Total Funds Eligible for Distribution.** The total funds eligible for distribution to VCO shall be calculated by multiplying the Gross Performance Year Savings by the VCO's selected level of risk sharing for the Performance Year. Mathematically, the calculation would be:

Gross Performance Year Savings x VCO Risk Sharing Percentage =Total Funds Eligible for Distribution

4.4 **Final Distribution to VCO**. All or a portion of the Total Funds Eligible for Distribution will be paid out to the VCO based on the VCO performance in a set of Quality Measures set for each Performance Year. The current measures and calculation of the distribution amount is outlined in the Quality Performance Program Exhibit 1C. The Department shall owe the VCO in the form of a performance incentive the lesser of: (1) the percentage of the Total Funds Eligible for Distribution as determined from the Quality Performance Program; or (2) an amount equal to fifteen percent (15%) of the applicable Gross Target for the Performance Year.

Article V

5.1 **Payment by VCO in the Event of Performance Year Loss**. This Article V sets forth the methodology for determining the amount owed by VCO to Department in the event of a Performance Year Loss.

5.2 **Minimum Loss Threshold.** Gross Performance Year Loss must exceed one percent (1%) of the Gross Target to trigger VCO's liability to Department for any portion of Gross Performance Year Losses; provided, however, that if Gross Performance Year Loss exceeds the one percent (1%) threshold, all losses will be included in the calculation of VCO's liability to Department for a portion of Gross Performance Year Loss.

5.3 **VCO Obligation for Performance Year Loss.** The amount the VCO is required to pay the Department in the event of a Performance Year Loss shall be calculated by multiplying the Gross Performance Year Loss by the VCO's selected level of risk sharing for the Performance Year. Mathematically, the calculation would be:

Gross Performance Year loss x VCO Risk Sharing Percentage =Total Funds Owed to the Department

5.4 **Final Payment Obligation**. The VCO shall pay to the Department for its shared risk of Performance Year losses the lesser of: (1) the Total Funds Owed to the Department; or (2) an amount equal to fifteen percent (15%) of the applicable Gross Target for the Performance Year.

5.5 **Timely Reporting and Data Condition.** In addition to any other remedies available to VCO, in the event the Department does not timely fulfill its obligations under this Agreement to provide data and reports as set forth herein and in the separate Data Use Agreement and that the failed obligation had a material impact on performance, VCO shall submit written notice to the Department of such failed obligation and impact. If the Department does not resolve the issue and come into compliance with this Agreement or Data Use Agreement within 30 days of the written notice the VCO shall have no obligation to pay any part of a Performance Year Loss.

ARTICLE VI

6.1 **Settlement Process.** This Article VI sets forth the methodology for annual settlement for each Performance Year.

6.2 **Performance Year Report.** No later than sixty (60 days) following the end of each Performance Year, the Department shall provide to VCO a report showing the Participants Attributed to the VCO for the applicable Performance Year. The report shall

reflect the total number of months each Participant was Attributed to the VCO, the total number of months the Participant was enrolled in the Healthy Connections Program during the Performance Year, and the number of months during which the Participant was Assigned to a Healthy Connections Service Location participating in the VCO.

6.3 Performance Year Settlement Reports. No later than two hundred seventy (270) days following the end of the Performance Year, the Department shall provide to VCO reports including each of the following elements:

6.3.1 Draft Settlement. A draft settlement for the Performance Year, including the Department's calculation of amounts owed by Department to the VCO or owed by the VCO to the Department, if any.

6.3.2 Participant Report. A report reflecting the final list of Participants Attributed to the VCO and the risk score for each Participant.

6.3.3 Quality Performance Report. A detailed report showing the results of the Quality Performance Program, including detail of which Participants are included in the calculation and whether the performance measure was met for each included Participant.

6.3.4 Financial Performance Report. A detailed report sufficient to show the Department's calculations, and for VCO to validate the calculations, set forth in Articles III, IV and V of this Exhibit 1.

6.4 VCO Response to Draft Settlement Report. By a date no later than forty-five (45) days from the date when VCO receives the last of the Performance Year Settlement Reports, as defined in Article 6.3, VCO shall accept or object to the Draft Settlement in writing delivered according to the notice provisions of the VCO Agreement.

6.5 Dispute Resolution in the Event of Objection. If VCO objects to the Draft Settlement, such objection shall be resolved by following the dispute resolution provisions of the VCO Agreement.

6.6 Settlement Finalization. The Draft Settlement shall become final (the "Final Settlement") upon the later of the date upon which: (1) the Department receives VCO's written acceptance of the Draft Settlement; and (2) any objection raised by the VCO is finally resolved. Additionally, the Draft Settlement shall become final if the VCO fails to respond to the Department in writing regarding the Draft Settlement Report as described in Article 6.3 and Article 6.4.

6.7 Timing of Payment. In the event the Final Settlement reflects a Distribution owed by Department to the VCO, the Department shall make such payment within sixty (60) days

of the date upon which the Draft Settlement becomes final. In the event the Final Settlement reflects a Payment Obligation owed by VCO to the Department, the VCO shall make such payment within sixty (60) days of the date upon which the Draft Settlement becomes final and state funded appropriations allow. As used in this section, "days" shall be counted as calendar days.

Notice requirements - Any report or communication called for pursuant to this Article VI shall be delivered pursuant to the notice provision of the agreement; provided, however, that if the Department makes the report or data available through a portal or other on-line repository, the Department shall separately provide notice of the availability of the reports or data pursuant to the notice provisions.

Article VII

7.1 **Fee For Service Reimbursement.** This Article VII sets forth the rates and methodology of fee for service reimbursement to VCO Network Providers for covered services provided to Participants. All participating VCO providers and facilities will be reimbursed for services provided to all Participants under the reimbursement methodology defined in their Medicaid Provider Agreement. HCVC Primary Care Providers will continue to receive the PMPM Case Management fee as listed in their Medicaid contracts.

7.2 **Acute Care Hospital Reimbursement.** Acute Care Hospitals will be reimbursed for services provided to all Medicaid Participants at the rates defined in their Medicaid contract.

7.3 **All Other Facilities Reimbursement.** These facilities will be reimbursed for services provided to all Medicaid Participants at the rates defined in their Medicaid contract.

7.4 **Physicians and Other Professional Providers Reimbursement.** All other participating VCO providers will be reimbursed for services provided to all Medicaid Participants at the rates defined in their Medicaid contract. HCVC Primary Care Providers will also still receive the PMPM Case Management fee as listed in their Medicaid contracts.

7.5 **Adjustment to Account for Changes in Reimbursement.** If the Department changes its provider reimbursement methodology or rates during the Performance Year, those changes shall be accounted for by increasing or reducing the Performance Year Gross Target PMPM for the Performance Year following the change in the methodology to the degree that it was impacted by those rates or methodology changes.

Exhibit 1A

Financial Terms -Year 3

Performance Year 3	January 1, 2024 – December 31, 2024
Base Year	July 1, 2021 – June 30, 2022
Statewide Base Year Actual Cost	$227.17
Statewide Base Year Member Months	4,099,830 (Legacy + Expansion)
Statewide Base Year Actual Cost PMPM	$ 227.17
Statewide Base Year Risk Score	1.641
VCO Base Year Risk Score	
Statewide Risk Standardized PMPM	$ 138.44
Statewide Annual Program Change Factor	0%
Level of Risk Sharing	

Exhibit 1B

Healthy Connections Value Care Program

Included & Excluded Services

Included Costs. The following costs shall be included when calculating Actual Cost:

Diagnostic services (lab tests, imaging, etc.)
Durable medical equipment
Emergency medical transport
Hospice Care
Home Health services
Inpatient Hospital services
Outpatient Hospital services
Inpatient behavioral health
Outpatient facilities including ambulatory surgery
Professional services (primary care, specialty care, physical therapy, speech therapy, etc.)

Excluded Costs. The following costs shall be excluded when calculating Actual Cost:

Behavioral health services administered through a managed-care contract
Dental services administered through a managed-care contract
Home and Community-Based Waiver Services (e.g. services provided to participants in their home or community rather than institutions, such as personal care services or meals)
Long-term Supports & Services
Non-emergent medical transportation services administered through a managed-care contract
Nursing Home or Intermediate Care Facilities
Pharmacy
Skilled Nursing
Healthy Connections Case Management Payments

Excluded Participant Categories.

This paragraph identifies the categories of Medicaid Participants who may be Assigned to a Healthy Connections Service Location within the VCO, but who are excluded from the Total Cost of Care calculation and the Quality Performance Program. Medicaid Participants not Assigned to a Healthy Connections Service Location are excluded from this Agreement.

- Dual-eligible Participants (eligible for both Medicaid and Medicare)

Exhibit 1C
Quality Performance Program

The goal of the Quality Performance Program is to incentivize continuous improvement in measured performance areas. The Healthy Connections Value Care Program is using quality measures to show how well the VCO is improving care and making quality care accessible while appropriately reducing the Actual Cost.

Idaho Medicaid will be collaborating with participating VCOs and a broad group of stakeholders on the development of future year quality measures to make sure the measures are important to both participants and VCOs and will achieve the goal of improving population health outcomes and reducing healthcare costs. Each year Idaho Medicaid will publish, by the end of the third quarter, the set of Quality Measures that will apply to participating VCOs the following year. All qualifying Quality Measures are included in the VCO's Quality Pool Funds payment calculation. To be considered a "qualifying" Quality Measure, the VCO shall have a minimum of thirty (30) Participants in the Base & Performance Year included in the measure's denominator. The Quality Measure's Baseline Score will be determined as follows:

- Performance Year to be based on Participants Attributed to the VCO for the Base Year.

The Quality Measure performance outcome will be calculated annually based on the Participants Attributed to the VCO as of the last day of the performance period.

Quality Pool Performance Payment Targets
Payments to the VCO from the Quality Pool will be established based on its performance in meeting Quality Measure improvement targets or Statewide Goal, as outlined below. Targets will be re-evaluated based on the prior year performance (baseline).

Statewide Goal
The Statewide Goal is set at the higher of the state average or the National 75th percentile. National Committee for Quality Assurance (NCQA) measures are set at the National-Health Maintenance Organizations (HMO) benchmarks. Non NCQA CMS Core Set benchmarks are set at the most recent Medicaid federal fiscal year reports available. Modified measures are set at the Base Year statewide average. Exceptions may be made and will be noted in Exhibit 1C Table 2.

Mandatory Measures
All VCOs are required to report on mandatory measures.

Optional Measures

All VCOs are required to select optional measures from the list which can be found in Exhibit 1C Table 2.

There will be three (3) mandatory measures that equal ten (10) points each. VCOs will select optional measures that will bring the total points to sixty (60) points. Applicable measures, point totals, and corresponding statewide goals can be found in exhibit 1C table 2.

Incremental Annual Improvement Targets

VCO shall demonstrate the greater of (1) 10% incremental increase from the difference between the state goal and VCO baseline score, or (2) an increase of 3 percentage points from their individual baseline score, to qualify for incentive payments; unless the VCO baseline score is less than 3 percentage points from the state goal, when achieving the state goal gains credit for the measure. Improvement targets encourage continued, incremental year-over-year improvement toward the statewide benchmark over time. Each VCO's Quality Measure Performance Target will be published by the Healthy Connections Value Care Program prior to the Performance Year.

The 10% incremental increase is calculated as follows:

$$\frac{\text{[State Goal]} - \text{[VCO Baseline]}}{10} = X\ \text{[VCO Baseline]} + [x] = \text{Improvement Target}$$

For example: a VCO's baseline for the timeliness of well-child visits in first 15 months measure may be 30%. Idaho has set the goal at 70%.

$$\frac{[70] - [30]}{10} = 40 \qquad [30] + [4] = 34 = \text{Improvement Target}$$

The VCO must reduce the gap between its baseline and the goal by 10%; therefore, the VCO must improve its rate on the timeliness of well-child visits in first 15 months measure by percentage points, resulting in an improvement target of 34%.

The VCO must meet either the statewide goal of 70% or the improvement target of 34% to be awarded quality performance payment funds for this measure.

Improvement Target with Floor Calculations

In some cases, depending on the difference between the statewide goal and the VCO baseline, this method may result in very small improvements that may not represent statistically significant change.

For example: A VCO's baseline for the breast cancer screening may be 49.8%. The state benchmark could be set at 51.0%.

Initial calculation	*Improvement target*
[51.0] – [49.8] / 10 = 0.12	**49.8 + 0.12 = 49.92**

If the improvement target calculation for a VCO results in a percent improvement that is less than the minimum, the minimum takes precedence and is applied instead of the improvement target calculation. For example, if a VCO's baseline was 50.6% with the statewide goal set at 70.0% for the well child measure, the improvement target calculation results in only a 1.94 percentage point increase in the rate, the 3-percentage point minimum is used instead to determine an improvement target.

Using the formula**,** based on State's Aspirational goal = 70%; VCO B's baseline = 50.6%

Initial calculation to minimum floor	*Improvement target*	*New Improvement target due*
[70.0] – [50.6] / 10 = 1.94	**50.6 + 1.94 = 52.94**	**50.6+ 3.0 = 53.6**

However, if a second VCO's baseline was only 35% on this measure, its improvement target would be greater than the 3-percentage point floor, and the floor would not be applied. Its improvement target would remain the initial calculation.

Initial calculation	*Improvement target*	*New improvement target with floor applied.*
[70.0] – [35.0] / 10 = 3.5	**35.0 + 3.5 = 38.5**	**Not needed; greater than 3% improvement**

In some instances, the improvement target calculation for a measure could exceed the established statewide goals. In this case, the VCO must only meet the statewide goal to be awarded the quality pool funds for that measure. For example, with the breast cancer measure, the state benchmark is set at 68.0% for Performance Year 1. A VCO has a baseline of 66.7. Using the formula:

Initial calculation	*Improvement target*	*New improvement target with floor applied*
[68.0] – [66.7] / 10 = 0.13	**66.7 + 0.13 = 66.8**	**66.7 +3 = 69.7**

But: the individual improvement target in this case is the state benchmark = 68.0

The calculated improvement target (69.7%) is higher than the established goal (68.0%). The VCO must only meet the goal of 68.0% to be awarded the quality pool funds for this measure. It does not need to meet the calculated improvement target when the improvement target is higher than the goal to qualify.

Quality Pool Performance Payments
If the statewide goal is met or the improvement target reached for a specific measure, the VCO receives credit for that measure, regardless of performance on other measures.

Quality Performance Payment Distribution
As an organization meets more statewide goals or improvement targets, it receives a higher payment (see Exhibit 1C Table 1 *Quality Performance Payment Distribution* below). If the VCO does not meet the improvement target or statewide goal on any of their selected measures, the VCO would not receive any quality performance payment funds.

Exhibit 1C Table 1: Quality Performance Payment Distribution

Applicable Points	Savings Payout
50-60	100%
40-45	75%
30-35	50%
20-25	25%
10-15	10%
0-5	0%

Exhibit 1C Table 2 PY3 Healthy Connections Quality Measures

Mandatory/ Optional	PY3 Healthy Connections Quality Measures	Points	Benchmarks
MANDATORY	**Emergency department visits per 1,000 member months** indicates the number of emergency department visits in an ambulatory care setting based on paid claims data. The number of visits is based on the count of unique patient and service date combinations. The measure includes only ER visits that did not result in an admission.	**10**	**Statewide Average**
MANDATORY	**W30-CH Well Visit GE 6 in First 15 Months** indicates percentage of children, who turned 15 months old, And had a specified number of well-child visits with a primary care practitioner (PCP) during their first 15 months of life. Excludes patients in hospice during the measurement year.	**10**	**75th percentile**

MANDATORY	**WCV-CH Well Care Visits Adolescents (ages 3 to 21)** indicates the percentage of adolescents, aged 3-21 years, who had at least one comprehensive well-care visit with a primary care physician (PCP) or a gynecologist during the measurement year.	**10**	**75th percentile**
OPTIONAL	**HEDIS BCS BREAST CANCER SCREENING** indicates the percentage of women, aged 52 to 74 years at the end of the measurement period, who had a mammogram done during a twenty-seven (27)- month measurement period.	**10**	**75th percentile**
OPTIONAL	**Readmissions within 30 days age 18-64** Calculates the percentage of acute inpatient stays during the reporting time period, for Participants aged 18 to 64, that were followed by an acute readmission for any diagnosis, excluding pregnancy-related stays, within thirty (30) days of discharge	**5**	**Statewide Average**
OPTIONAL	**Diabetes HbA1C Testing** Indicates the percentage of patients with type 1 or type 2 diabetes, aged 18 to 75 years, who had an HbA1c test done.	**5**	**Statewide Average**
OPTIONAL	**Well-Child Visits for Age 15 Months–30 Months** indicates percentage of children, who turned age 30 months during the measurement year and had a specified number of well-child visits with a primary care practitioner (PCP):Two or more well-child visits. Excludes patients in hospice during the measurement year.	**10**	**75th percentile**
OPTIONAL	**COB-AD: CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES** indicates the percentage of beneficiaries ages 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded.	**10**	**75th percentile**
OPTIONAL	**DEV-CH: DEVELOPMENTAL SCREENING IN THE FIRST THREE YEARS OF LIFE** indicates the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	**10**	**75th percentile**
OPTIONAL	**CDF-CH: SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17** indicates the percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized	**10**	**75th percentile**

	depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.		
OPTIONAL	**CDF-AD: SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER** indicates the percentage of beneficiaries ages 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.	**10**	**75th percentile**
OPTIONAL	**FUH-CH: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS: AGES 6 TO 17** indicates the percentage of discharges for beneficiaries ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. • Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge	**5**	**75th percentile**
OPTIONAL	**FUH-CH: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS: AGES 6 TO 17** indicates the percentage of discharges for beneficiaries ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge	**5**	**75th percentile**
OPTIONAL	**FUH-AD: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**: AGE 18 to 64 indicates the percentage of discharges for beneficiaries age 18 to 64 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. • Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge.	**5**	**75th percentile**
OPTIONAL	**FUH-AD: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS: AGE 18 to 64** indicates the percentage of discharges for beneficiaries age 18 to 64 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:	**5**	**75th percentile**

	• Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge.		

Exhibit 1D
Attribution Methodology

Participants are Attributed to a VCO for purposes of calculating the Total Cost of Care (TCOC) formula and Quality Program as follows:

1. Prior to the beginning of each Performance Year the VCO must identify the Healthy Connections Service Locations (HCSL) participating with the VCO in the Healthy Connections Value Care (HCVC) Program.
2. Participants will be Attributed to a VCO based on the Participant's Assignment to a VCO-participating Healthy Connections Service Location in accordance with the policies and procedures of the Healthy Connections Program.
3. For a Participant's cost and member months to be included in the Base Year calculation, a participant must be enrolled in Healthy Connections for a minimum of seven (7) month. For a Participant's cost and member months to be included in the Performance Year, the Participant must be Assigned to the VCO a minimum of seven (7) months. A Participant may be Assigned to different Healthy Connections Service Locations within the same VCO to qualify.
4. Included in the calculation of the VCO's TCOC will be all member months and TCOC claims (Actual Costs) paid during the period of Attributed Participants while the Participant was a Healthy Connections Program Participant. For example, if a Participant was Assigned to a HCSL in VCO one (1) for seven (7) months and another HCSL in VCO two (2) for five (5) months, all twelve (12) member months and all claims paid for the year would be Attributed to VCO 1.
5. Examples of Attribution process.

<u>Ex 1: 12 months of Healthy Connections Program eligibility</u>

- 7 months Assigned to VCO 1
- 5 months Assigned to VCO 2

Participant would be Attributed to VCO 1 for the entire 12-month period and all claims incurred during the period would be Attributed to VCO 1 and included in the TCOC calculation.

<u>Ex. 2: 7 months of Healthy Connections Program eligibility</u>

- 7 months Assigned to VCO 1
- 5 months eligible for Medicaid but not enrolled in the Healthy Connections Program

Participant would be Attributed to VCO 1 for the 7 months they were assigned to VCO 1 and all claims incurred during the period would be Attributed to VCO 1 and included in the TCOC calculation.

<u>Ex. 3: 10 months of Healthy Connections Program eligibility</u>

- 7 months Assigned to VCO 1

- 3 months Assigned to VCO 2
- 2 months eligible for Medicaid but not enrolled in the Healthy Connections Program

Participant would be Attributed to VCO 1 for the10-month period that the participant was enrolled in the HCVC Program, and all claims incurred during the period would be Attributed to VCO 1 and included in the TCOC calculation.

Ex. 4: 12 months of Healthy Connections Program eligibility

- 6 months Assigned to VCO 1
- 6 months Assigned to VCO 2

Participant would not be Attributed to either VCO or included in the Base Year calculation due to the Participant not meeting the 7-month minimum Assignment requirement to qualify for Attribution.

Ex 5: 9 months of Healthy Connections Program eligibility

- 7 months Assigned to VCO 1
- 2 months Assigned to VCO 2
- 3 months eligible for Medicaid but not enrolled in the Healthy Connections Program

Participant would be Attributed to VCO 1 for the 9-month period that the Participant was enrolled in the HCVC Program, and all claims incurred during the 9-month period would be Attributed to VCO 1 and included in the TCOC calculation.

Ex. 6: 6 months of Healthy Connections Program eligibility

- 6 months Assigned to VCO 1

Participant would not be Attributed to VCO 1 or included in the Base Year calculation due to the Participant not meeting the 7-month minimum Assignment requirement to qualify for Attribution.

Exhibit 2
Value Care Organization

Data Deliverables

This Exhibit 2 sets forth additional terms for purposes of a Value Care Organization participating in the Value-Based Incentive Payment program; provided, however**,** in the event of a discrepancy or conflict between this Exhibit and the VCO Agreement, this Exhibit will take precedence.

ARTICLE I

1.1 **Department Reporting Obligations.** The Department shall provide to the VCO the reports listed in this exhibit.

1.2 **Participant Enrollment Report.** Participant enrollment data, outlined in the Data Dictionary found in Article III, for participants assigned to Healthy Connections Service Locations participating with a VCO. The VCO shall receive this report during the Performance Year and for a period prior to the Performance Year as defined in Article II.

1.3 **Participant Attribution Report.** A report reflecting the Assigned Participants, outlined in the Data Dictionary found in Article III, who qualify as Attributed Participants to the VCO during the Base Year for purposes of determining the VCO's Gross Target PMPM. Report will also include the total number of Healthy Connections Program Member Months for each Attributed participant for the Base Year.

1.4 **MARA Risk Score.** A report reflecting the MARA risk score for each Participant Attributed to the VCO during the Base Year for purposes of determining the VCO's Gross Target PMPM. Additional MARA Risk Score reports will be provided to the VCO for each Participant Assigned to the VCO during the Performance Year, as defined in Article II.

1.5 **Medical Claims Report.** VCO shall receive medical claim data, outlined in the Data Dictionary found in Article III, for Participants Assigned to the VCO during the Performance Year and for a period prior to the Performance Year as defined in Article II.

1.6 **Pharmacy Claims Report.** VCO shall receive pharmacy claims data, outlined in the Data Dictionary found in Article III, for Participants Assigned to the VCO during the Performance Year and for a period prior to the Performance Year as defined in Article II.

1.7 **Total Cost of Care (TCOC) Saving/Loss Report.** An initial TCOC Savings/Loss report reflecting the final Base Year figures (as set forth in Exhibit 1A), including Base Year Statewide Actual Cost PMM, Statewide Risk Score, Statewide Risk Standardized PMPM and Annual Program Change Factor. Interim updates of the VCO's TCOC calculation will be provided during the Performance Year, as set forth in Article II.

1.8 **Quality Performance Program Report.** An initial report reflecting the VCO's quality performance will be provided prior to the Performance Year, containing the VCO quality baseline data, Statewide Quality Average, Statewide Quality Targets, VCO's quality

targets and quality performance for current member enrollment. Interim updates of the VCO's Quality Performance will be provided during the Performance Year, as set forth in Article II.

1.9 **Gaps in Care Report**. A report reflecting a list of participants Assigned to Healthy Connections Service Locations participating with a VCO and indicating if the applicable quality measure(s) numerator and denominator criteria have not been met. This report to be provided during the Performance year as defined in Article II.

1.10 **Preliminary data.** All data presented during the performance year is preliminary and subject to change.

1.11 **Data limitations**. The Department can only receive claims-based data. Supplemental data including LOINC, CPT-II and SNOMED codes and chart reviews are not accepted and will not be included in Base Year and Performance Year quality measure scores.

Article II

The chart below identifies the time frames for data deliverables in the Base Year and Performance Year.

Base Year Data – Prior to Performance year			
File Name	**Data Included**	**Timeframes of Data**	**Delivery Date**
Participant Enrollment Report	Enrollment data for Participants Attributed to HC Service Locations affiliated with VCO during the Base Year. Included in "flat files."	July 1, 2021 -June 30, 2022	October 31, 2023
Medicaid Claims Data	Medical claims data for Participants Attributed to HC Service Locations affiliated with VCO during the Base Year. Included in "flat files."	Dates of Services between July 1, 2021 -June 30, 2022 and a paid date between July 1, 2021 -December 31, 2022	October 31, 2023
Pharmacy Claims Data	All pharmacy claims data for Participants Attributed to C Service Locations affiliated with VCO during the Base Year. Included in "flat files."	Dates of Services between July 1, 2021 -June 30, 2022 and a paid date between July 1, 2021 – December 31, 2022	October 31, 2023
MARA Risk Score	MARA individual risk score for each Participant Attributed to the VCO during the Base Year	July 1, 2021 -June 30, 2022	October 31, 2023
TCOC Savings/Loss Report	Initial TCOC Savings/Loss report, to include final Base Year figures	TCOC Target - July 1, 2021 - June 30, 2022 (limited to run	October 31, 2023

		out no later than December 31, 2022);	
Quality Performance Program Report	Initial Quality Performance Report, to include target data for Participants Attributed to HC Service Locations affiliated with VCO during the Base Year and quality performance data for Participants currently Assigned to HC Service Locations affiliated with the VCO.	Target based on Quality Performance as of June 30, 2022. Timeframe of data dependent on each measure criteria.	October 31, 2023

Performance Year Data – CY 2024			
File Name	**Data Included**	**Timeframes of Data**	**Date will receive**
Participant Enrollment Report	Enrollment data for Participants (if ever) Assigned to the HC Service Locations affiliated to a VCO during the Performance Year. Included in "flat files."	Start of Base Year to current month with a full monthly refresh of data	Provided monthly on or before the last day of the following month.
Medical Claims data	Medical Claims data for Participants (if ever) Assigned to the Healthy Connections Services Locations affiliated to the VCO during the Performance Year. Included in "flat files."	Start of Base Year to current month with a full monthly refresh of data	Provided monthly on or before the last day of the following month.
Pharmacy Claims Data	Pharmacy Claims data for Participants (if ever) Assigned to the Healthy Connections Services Locations affiliated to the VCO during the Performance Year. Included in "flat files."	Start of Base Year to current month with a full monthly refresh of data	Provided monthly on or before the last day of the following month.
MARA Risk Score Report	Report to include participant level risk scores for all Participants Assigned to the VCO at the end of the reporting quarter	Twelve (12) months prior to the last day of the quarter	Provided quarterly on or before the last day of the second month following the quarter. 1st Quarter: On or before May 31st. 2nd Quarter: On or before August 31st. 3rd Quarter: On or before November 30th. 4th Quarter: On or before February 28th.
TCOC Savings/Loss Report	The report will provide the VCO with interim updates to their TCOC calculation based on Participants Assigned to the VCO at the end of the reporting quarter.	Performance Year effective date – to last day of the reporting quarter	Provided quarterly on or before the last day of the second month following the quarter.

			1st Quarter: On or before May 31st. 2nd Quarter: On or before August 31st. 3rd Quarter: On or before November 30th. 4th Quarter: On or before February 28th.
Quality Performance Program Report	This report will provide a quarterly update of the VCO's Quality Measure performance for each affiliated Healthy Connections Service Location based on participants Assigned to the VCO at the end of the reporting quarter	Will include claims paid up to four months prior to the date of the report, allowing for claim lag, and a look-back period contingent upon specific quality measure parameters	Quality Performance through December 31: On or before May 1st. Quality Performance through March 31: On or before August 1st. Quality Performance through June 30: On or before November 1st. Quality Performance through September 30: On or before February 1st. Quality Performance through December 31: On or before May 1st
Gaps in Care Report	A monthly listing of all participants, assigned to the Healthy Connections Service Locations affiliated to the VCO, indicating if the applicable quality measure(s) numerator and denominator criteria have not been met	Will include claims paid up to the date of the report and look-back period contingent upon specific measure parameters	Provided monthly on or before the last day of the month

Article III

DATA USE AGREEMENT

Between
Idaho Department of Health and Welfare
And
VCO

This DATA USE AGREEMENT is hereby made and entered into effective _____, by and between the Idaho Department of Health and Welfare ("Department"), an Idaho state agency, and the undersigned Value Care Organization ("VCO") in connection with the Agreement Under the Healthy Connections Value Care Program as a Value Care Organization (together with its exhibits and attachments, the "VCO Agreement") separately entered into by the Department and VCO. The Department and VCO may each be referred to as a Party, and collectively as Parties. Capitalized terms in this Agreement shall have the same meanings as those set forth in the VCO Agreement.

The Parties agree as follows:

1. **Purpose**. The purpose of this Data Use Agreement is to establish the terms and conditions under which the Department and the VCO will share data and information as required to fulfill the parties' respective duties and responsibilities as set forth in the VCO Agreement.

2. **Department's Duty to Provide VCO Data and Information**. The Department shall deliver to VCO data conforming to the requirements and specification of, and at the times set forth in this Exhibit, (the "Department Data"). The Department shall provide the required claims data to the VCO for any member Assigned to an affiliated Service Location at any time during the performance year. The forms, data dictionary, reports, requirements, specifications, and timing set forth in this Exhibit may only be changed by written agreement of the Parties. The Department shall provide at least sixty (60) days' advance written notice of any proposed changes.

3. **VCO's Duty to Provide Department Data and Information**. VCO shall deliver to the Department data conforming to the requirements and specification of, and at the times set forth in this Exhibit (the "VCO Data"). VCO's duty shall be limited to data related to VCO Network Providers. The forms, data dictionary, reports, requirements, specifications, and timing set forth in this Exhibit may only be changed by written agreement of the Parties. VCO shall provide at least sixty (60) days' advance written notice of any proposed changes.

4. Privacy and Security Safeguards.

4.1 Confidential Information. Neither Party or its agents will disclose any of the other Party's data to any third party except as specifically stated in this Agreement, as required by law, or as agreed to in writing by the other Party. This provision shall survive termination of this Agreement.

4.2 Processes and Policies to Safeguard Data. VCO and Department will use appropriate administrative, technical, and physical safeguards to protect the confidentiality, integrity, and availability of information and to prevent the use or disclosure of any data received from the other Party, except as permitted or required by applicable federal or state law, the VCO Agreement, or this Data Use Agreement.

4.2.1 VCO and Department shall: (i) provide for appropriate identification and authentication of authorized users; (ii) provide appropriate access authorization; (iii) guard against unauthorized access to Department Data or VCO Data; and (iv) provide appropriate security audit controls and documentation.

4.2.2 VCO and Department shall apply appropriate sanctions against any person, subject to VCO's or Department's control or authority, who fails to comply with safeguards established under Section 4.2. VCO and Department shall make employees, agents, and contractors aware that certain violations may result in notification by VCO or Department to law enforcement officials as well as regulatory, accreditation and licensure organizations.

4.3 Protected Health Information. No Party or its agents will disclose any protected health information ("PHI") except as required by law or as provided in the VCO Agreement or this Data Use Agreement. Any Disclosure must comply with all applicable federal and state laws and regulations, including but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 and its implementing regulations on privacy and security found at 45 C.F.R. Parts 160 and 164 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act, Pub. L. No. 111-5, Title XIII (2009), as applicable to the Parties and as the same may be amended from time to time.

4.4 Business Associate Agreement. VCO and Department shall enter into a separate Business Associate Agreement, Exhibit 3, permitting VCO to create, receive, maintain, or transmit electronic PHI on the Department's behalf.

5. Retention and Use of Data. Unless otherwise specified herein, each Party shall use the data and information by the other Party, as well as any abstracts, summaries, or other works derived from or based upon such data, solely for purposes of performing their respective obligations under the VCO Agreement.

5.1 **VCO Permitted Uses and Disclosures**. VCO may use the data and information provided by the Department to monitor the performance of VCO Network Providers, to improve the quality of care provided by VCO Network Providers, and to disclose such data, and information derived from them to VCO Network Providers to the extent reasonably necessary to achieve these purposes.

5.2 **Disclosure by VCO to Designated Affiliates and Designated Vendors**. If reasonably necessary to carry out its duties and obligations under the VCO Agreement, VCO may disclose and transfer Department Data in part or in whole to a parent organization, wholly owned subsidiary, or affiliate under common ownership or control of the same parent organization(s) as VCO (each a "Designated Affiliate"). In addition, VCO may disclose and transfer Department Data in part or in whole to a third-party data analytics or processing firm other than a Designated Affiliate (each a "Designated Vendor"), provided that the Designated Vendor and VCO have first executed a written agreement, which may be in the form a Subcontractor Business Associate Agreement, pursuant to which the Designated Affiliate or Designated Vendor agrees to protect and safeguard Department Data and PHI to the same degree and extent as provided in this Data Use Agreement and the Business Associate Agreement between the VCO and Department.

5.3 **Prohibition on Certain Use of Data by VCO**. VCO may not disclose or transmit Department Data to any person or in any manner that is not specifically authorized by the VCO Agreement or this Data Use Agreement. Apart from disclosure to Designated Affiliates and Designated Vendors, VCO may not publish or further disclose the Department Data to any third parties not contemplated or named in this Agreement without the written consent of the Department, except as may be required by law.

5.4 **Expressly Permitted Use by VCO of Data**. VCO may from time to time make use of Department Data in de-identified form to publish, distribute, create derivative works, or works based on the Department Data, and otherwise exploit the de-identified Department Data to enhance innovation and further the causes set forth herein, subject to: a) HIPAA data restrictions of any Protected Health Information (PHI); and b) in accordance with provisions of any applicable BAA in place between parties.

6. **Term and Termination.** This Agreement shall commence on the Effective Date above and continue in effect until the termination of the VCO Agreement. Breach of the terms of this Data Use Agreement shall be considered a breach of the VCO Agreement. This Data Use Agreement may be terminated in the same manner as breach of the VCO Agreement.

6.1 **Effect of Termination**. Parties shall extend the protections of this Data Use Agreement to any data in its possession that it does not destroy or return to the

other Party and shall limit further uses and disclosures of the data to those expressly authorized by the VCO Agreement or this Data Use Agreement.

7. General Terms and Conditions.

7.1 Notices. Any notices required by this Data Use Agreement shall be sent according to the requirements of notice set forth in the VCO Agreement.

7.2 Amendment. This Data Use Agreement may only be amended in a writing signed by the Parties.

7.3 Relationship. Each Party will perform its obligations pursuant to this Data Use Agreement as an independent contractor. Nothing contained in this Data Use Agreement is intended to give rise to any agency, subcontractor, partnership, or joint venture relationship between the Parties or to impose upon the Parties any of the duties or responsibilities of such a relationship.

7.4 Assignment. Neither this Data Use Agreement nor any interest hereunder may be assigned or otherwise transferred by any party to any third party other than their respective affiliates without the prior written consent of the other party.

7.5 Compliance with Law. The Parties shall comply with all applicable federal and state of Idaho laws, rules, and regulations, including, without limitation, those laws and regulations governing the maintenance of clinical or medical records and confidentiality of patient information as well as with all standards promulgated by any applicable accrediting agency.

7.6 Governing Law. The parties acknowledge that this Data Use Agreement has been negotiated and entered in the state of Idaho. The parties expressly agree that this Data Use Agreement shall be governed by, interpreted under, and construed and enforced in accordance with the laws of the state of Idaho.

7.7 Third Party Beneficiaries. This Data Use Agreement does not confer any legal rights on any third party, nor is it the intention of any Party hereto to create or confer any rights.

7.8 Vendor/Affiliate Compensation. The Parties hereby agree that any applicable fee(s) due for services provided to VCO by a Designated Affiliate or Designated Vendor shall be the sole responsibility of VCO.

7.9 Severability. Each provision of this Data Use Agreement shall be interpreted in such a manner as to be effective and valid under applicable law, however, if any provision is deemed to be invalid or unenforceable for any reason, then the Data Use Agreement shall be ineffective as to that provision only, and the remainder shall continue in full force and effect.

7.10 Interpretation. This Data Use Agreement shall be interpreted, to the maximum extent possible, to comply with applicable federal and state laws and regulations, including, but not limited to, HIPAA.

7.11 Waiver. Any provision of this Data Use Agreement may be waived by the Party entitled to the benefit of such provision, provided that such waiver shall be in writing. Waiver of any breach or provision will not be construed as a waiver of any successive breach or provision.

7.12 Entire Agreement. This Data Use Agreement, together with the exhibits attached hereto, along with the VCO Agreement and its associated exhibits and attachments, represent the entire understanding between the Parties with respect to its subject matter.

8. DATA LAYOUT AND DICTIONARY

8.1 Data Deliverable Templates. The Department will provide the following deliverable templates to the VCO on execution of this agreement:

Data Dictionary
Quality Program Performance Dashboard
Gap in Care Report
Total Cost of Care

Exhibit 3

Value Care Organization

Business Associate Agreement
With
{Name of Organization}

Specific obligations and activities of **{Name of Organization}** to protect confidential information in accord with HIPAA privacy and security requirements in compliance with 45 CFR § 164.504(e).

Obligations of Contractor:

{Name of Organization} agrees to not use or disclose confidential information other than as permitted or required by the contract or as required by law.

{Name of Organization} agrees to use appropriate safeguards, and to comply with Subpart C of 45 CFR Part 164 with respect to electronic confidential information, to prevent use or disclosure of confidential information other than as provided for by this contract.

{Name of Organization} agrees to report to the Department any use or disclosure of confidential information not provided for by this contract of which it becomes aware, including breaches of unsecured confidential information as required at 45 CFR § 164.410, and any security incident of which it becomes aware. Reporting to the Department will be done no later than 10 business days after discovery of breach.

{Name of Organization} agrees to ensure that any agent, including any subcontractors, that create, receive, maintain, or transmit confidential information on behalf of the Contractor agree to the same restrictions, conditions, and requirements that apply through this contract to Contractor with respect to such information.

{Name of Organization} agrees to provide access to confidential information, at the request of Department, and in the time and manner as directed by Department, to an individual to meet the requirements under 45 CFR § 164.524.

{Name of Organization} agrees to make any amendment(s) to confidential information that the Department directs or agrees to pursuant to 45 CFR § 164.526 at the request of Department or an individual.

{Name of Organization} agrees to make internal practices, books, and records, including policies and procedures relating to the use and disclosure of confidential information received

from, or created or received by Contractor on behalf of the Department available to the Secretary of Health and Human Services, in a time and manner designated by the Secretary, for purposes of the Secretary determining Department's compliance with the Privacy Rule.

{Name of Organization} agrees to document any disclosures of confidential information and information related to such disclosures as would be required for Department to respond to a request by an individual for an accounting of disclosures of confidential information in accordance with 45 CFR § 164.528.

{Name of Organization} agrees to provide to Department or an individual information collected in accordance with this contract, to permit Department to respond to a request by an individual for an accounting of disclosures of confidential information in accordance with 45 CFR § 164.528.

Permitted Uses and Disclosures by **{Name of Organization}**

a. Except as otherwise limited in this contract, **{Name of Organization}** may use or disclose confidential information to perform functions, activities, or services for, or on behalf of, Department as specified in the scope of work provided that such use or disclosure would not violate the privacy, breach notification or security rule if done by Department or the minimum necessary policies and procedures of the Department.

b. **{Name of Organization}** may also use or disclose confidential information as required by law or other arrangement pursuant to 45 CFR § 164.504(e)

c. **{Name of Organization}** may use confidential information to report violations of law consistent with 45 CFR § 164.502(J)(1).

Obligations of Department

a. Department shall notify **{Name of Organization}** of any limitation(s) in its notice of privacy practices of Department in accordance with 45 CFR § 164.520, to the extent that such limitation may affect **{Name of Organization}** 's use or disclosure of confidential information.

b. Department shall notify **{Name of Organization}** of any changes in, or revocation of, permission by an individual to use or disclose confidential information, to the extent that such changes may affect **{Name of Organization}** 's use or disclosure of confidential information.

c. Department shall notify **{Name of Organization}** of any restriction to the use or disclosure of confidential information that Department has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect **{Name of Organization}** 's use or disclosure of confidential information.

Permissible Requests by Department

Department shall not request **{Name of Organization}** to use or disclose confidential information in any manner that would not be permissible under the privacy or security rule if done by Department.

a. Action upon Termination of the Contract

Upon termination of this contract, for any reason, **{Name of Organization}** shall return or destroy all confidential information received from Department, or created, maintained or received by **{Name of Organization}** on behalf of Department.

In the event that **{Name of Organization}** determines that returning or destroying the confidential information is infeasible, **{Name of Organization}** shall notify the Department of the conditions that make return or destruction infeasible. If the Department agrees that return or destruction of confidential information is infeasible, **{Name of Organization}** shall extend the protections of this contract to such confidential information and limit further uses and disclosures of such confidential information to those purposes that make the return or destruction infeasible, for so long as **{Name of Organization}** maintains such confidential information. **{Name of Organization}** shall also continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic confidential information if return or destruction is infeasible.

Exhibit 4

Value Care Organization

Hospital and Healthy Connections Service Location Affiliation Listings

VCO Network Provider List. VCO agrees to furnish Department with the Tax IDs and Healthy Connections Service Location and Acute Care Hospital information necessary for the Department to execute the obligations of this section no later than one hundred and twenty (120) days prior to each Performance Year, except as may otherwise be determined by the Department.

Acute Care Hospital Locations (if applicable)				
Organization Name	Service Location Name	Address	Tax ID	

Healthy Connections Service Locations (separate attached document will be accepted)				
Organization Name	Service Location Name as listed on HC network listing	Address	NPI HC PMPM Paid To	Tax ID HC PMPM Paid To

