**OneCare Vermont Accountable Care Organization, LLC**
**Board of Managers Meeting Agenda**
**September 17, 2019**
**4:30 p.m. – 7:00 p.m.**
**Central Vermont Medical Center – Conference Room 1**

| Time | Agenda Item | Presenter |
|---|---|---|
| 4:30 p.m. | Call to Order | John Brumsted |
| 4:32 p.m. | Introduce New Board Members | John Brumsted |
| 4:35 p.m. | Consent Agenda Items - Approval*<br>*Vote to approve Consent Agenda Items* | John Brumsted |
| 4:35 p.m. | Policies*<br>• CPR Policy 2020<br>• Data Transparency Policy<br>• Data Use Policy<br>• Compliance Plan<br>*Vote to approve policies as recommended by management* | Sara Barry/Tom Borys/Greg Daniels |
| 4:45 p.m. | Public Comment<br>Move to Executive Session | John Brumsted |
| 6:55 p.m. | Votes<br>1. Vote to Approve Execute Session Minutes from August 20, 2019<br>2. Vote to Approve Acceptance of Grant Funding Opportunity<br>3. Commercial Programs Vote<br>4. Vote to Approve 2020 Proposed OneCare VT Budget | John Brumsted |
| 7:00 p.m. | Adjourn | John Brumsted |

*Denotes Attachment

Attachments:

1. Consent Agenda Items
   - Draft of OneCare Board of Manager Minutes from August 20, 2019
   - Board Committee Report outs
   - Monthly Financials July
   - CMO Corner
2. OneCare Care CPR Policy for 2020
3. OneCare Data Transparency Policy
4. OneCare Data Use Policy
5. OneCare Compliance Plan

# ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
## BOARD OF MANAGERS MEETING
## AUGUST 20, 2019

## MINUTES

A meeting of the Board of Managers of OneCare Vermont Accountable Care Organization, LLC ("OneCare") was held at Central Vermont Medical Center on August 20, 2019.

I. Call to Order

Steve Leffler, M.D., called the meeting to order at 4:30 p.m.

II. Consent Agenda Items

The consent agenda items were approved unanimously.

III. Governance

The Banking resolution removing Kevin Stone and naming Vicki Loner as CEO, for the purposes of conducting financial transactions as required by the bank, was approved unanimously.

The Nomination Committee recommended Michael Costa, Executive Director of Northern Counties Healthcare, to fill the Federally Qualified Health Center seat on the Board that was vacated by Alison Calderara. Upon a motion being made and seconded, Michael Costa was elected to the Board by a supermajority effective September 1.

The Nomination Committee recommended Coleen Condon Kohaut, Owner of Suncrest Healthcare Communities, to fill the Skilled Nursing Facility seat on the Board that was vacated by Judy Morton. Upon a motion being made and seconded, Coleen Condon Kohaut was elected to the Board by a supermajority effective September 1.

The Nominating Committee recommended that Board Members, John Sayles and Judy Peterson be added to the Executive Committee. Upon a motion being made and seconded, John Sayles and Judy Peterson were elected to the Executive Committee effective September 1.

The Nomination Committee recommended Louis Josephson, MD, CEO of the Brattleboro Retreat, be seated on the Population Health Strategy Committee. Upon a motion being made and seconded, Louis Josephson was elected to the Population Health Strategy Committee by a supermajority effective September 1.

IV. Policies

Sara Barry reviewed the revised Care Coordination Policy for 2020. Upon a motion made and seconded, the Care Coordination Policy for 2020 was approved by a supermajority.

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V. Regulatory Update

Vicki Loner presented a summary of the recent CMMI Site visit. She reported that the general consensus by all involved was that the sessions involving OneCare and the Payers went extremely well. Ms. Loner thanked all those who participated. She thought that CMMI benefited from hearing directly from the providers about the positive impact that the All Payer Model and OneCare are having on their ability to improve delivering care. OneCare has committed to continue working with the GMCB and AHS to strengthen the relationships with CMMI, while continuing to work through necessary programmatic issues.

VI. Public Comment

There was no member of the public was in attendance.

VII. Executive Session

VIII. Voting

a. The motion to approve 2018 Value Based Incentive Fund disbursement and authorize management to make the payments was approved by a supermajority.

b. The motion to approve the second round of selected Innovation Pilots and Funding recommended by the Population Health Committee was approved by a supermajority of the Board, with Board managers whose organizations were involved in the selected projects recusing from the vote.

c. The motion to authorize management to pay Medicare for the All-Inclusive Population Based Payment 2018 reconciliation was approved by a supermajority.

d. The motion to authorize management to finalize the 2018 Blue Cross Qualified Health Plan Program settlement, and pay amounts due to Blue Cross was approved by the supermajority.

e. The motion to authorize management to finalize the settlement of 2018 Vermont Medicaid Next Generation Program and pay amounts due to DVHA was approved by a supermajority.

f. The motion to approve a revised executive committee effective in September was approved by a supermajority.

g. The motion to approve the Executive Session Minutes from July 16, 2019 was approved by a supermajority.

IX. Adjourn

Upon a motion made and seconded, the meeting adjourned at 6:42 p.m.

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**Attendance:**

OneCare Board Members

- ☒ Dan Bennett
- ☒ Jill Berry Bowen
- ☒ John Brumsted, MD
- ☐ Alison Calderara
- ☐ Betsy Davis
- ☒ Tom Dee
- ☒ Steve Gordon
- ☒ Joe Haddock, MD
- ☒ Tomasz Jankowski
- ☒ Todd Keating
- ☒ Sally Kraft, MD
- ☒ Steve LeBlanc
- ☒ Steve Leffler, MD
- ☒ Sierra Lowell
- ☐ Judy Morton
- ☐ Pamela Parsons
- ☒ Joseph Perras, MD
- ☒ Judy Peterson
- ☒ Toby Sadkin, MD
- ☐ John Sayles

OneCare Risk Strategy Committee

- ☐ Claudio Fort
- ☐ Jeffrey Haddock, MD
- ☐ Tom Manion
- ☒ Brian Nall
- ☐ Anna Noonan
- ☐ Shawn Tester

OneCare Leadership and Staff

- ☒ Vicki Loner
- ☒ Norm Ward, MD
- ☐ Joan Zipko
- ☒ Spenser Weppler
- ☒ Tom Borys
- ☒ Sara Barry
- ☒ Susan Shane
- ☐ Martita Giard
- ☒ Linda Cohen Esq.
- ☒ Amy Bodette

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# OneCare Board of Manager Committee Report-outs For September

***Executive Committee***
*At its September 4th meeting, the committee was provided an updated regulation activities including OneCare's submission of certification materials the previous day as well as an update on the Budget submission including the timeline. An update was provided on payer program negotiation as well as potential 2020 network participation as it currently stood. There was an update on ACO programs for 2020 including the Comprehensive Payment Reform (CPR) Project.*

***Finance Committee***
*At its September 11th meeting, the committee reviewed and discussed the July Financial Statements, 2018 Medicare Settlement, 2019 Program Performance Reports, 2020 CPR Policy. A 2020 Budget presentation and discussion was also held. Nominees for the Finance Committee were brought forth.*

***Population Health Strategy Committee***
*At its September 4th meeting, the committee members heard a presentation from Molly Dugan, the SASH Director, on the SASH Program Key Successes and Outcomes. A brief PHM Budget Planning Update was also provided along with updates on the Pediatric Work Group for the 2020 Complex Care Program, 2018 Medicare QM, and Review of the CPR Variable Component Policy. Dr. Ward provided a brief update on Algorex which wrapped up the meeting.*

***Patient & Family Advisory Committee***
*At its September 12th meeting, Dr. Toby Sadkin provided a presentation on primary care and time for questions and answers from the committee members.*

| | | |
|---|---|---|
| **Org** | 1555 | 1555 |
| **Year** | 2019 | 2019 |
| **Period** | **10** | **9** |
| **Data Type** | Actual | Actual |
| **Balance Type** | YTDBAL | YTDBAL |

**OneCare Vermont**
**Statement of Financial Position**

| **For the Periods Ended** | **7/31/2019** | **6/30/2019** | **Variance** |
|---|---|---|---|
| **ASSETS** | | | |
| **Current assets:** | | | |
| Unrestricted Cash | 22,452,873 | 5,672,403 | 16,780,471 |
| GMCB Reserve | 2,858,333 | 7,276,192 | (4,417,859) |
| CMS Reserve-US Bank | 4,163,865 | 4,160,958 | 2,907 |
| VBIF | 8,193,462 | 7,212,092 | 981,370 |
| Advance Funding-Medicaid | 8,895,881 | 9,875,967 | (980,086) |
| Total Cash | 46,564,415 | 34,197,611 | 12,366,803 |
| Network Recievable | 2,081,936 | 2,027,768 | 54,168 |
| Network Recievable-Settlement | 3,986,068 | 21,799,052 | (17,812,984) |
| Other Receivable | 7,201,466 | 6,642,814 | 558,651 |
| Other Receivable-Settlement | 5,904,399 | 5,904,399 | - |
| Prepaid Expense | 1,599,388 | 245,168 | 1,354,220 |
| **TOTAL ASSETS** | **67,337,671** | **70,816,812** | **(3,479,141)** |
| **LIABILITIES AND NET ASSETS** | | | |
| **Current liabilities:** | | | |
| Accrued Expenses | 2,304,692 | 2,224,017 | 80,675 |
| Accrued Expenses -Settlement | 25,339,272 | 26,248,370 | (909,097) |
| Network Payable | 17,843,425 | 17,975,960 | (132,535) |
| Network Payable-settlement | 4,405,502 | 4,405,502 | - |
| Notes Payable | 4,124,849 | 4,124,849 | - |
| Deferred Income | 1,724,481 | 673,773 | 1,050,708 |
| Due to Related Parties - UVMMC | 5,467,328 | 9,208,175 | (3,740,847) |
| Due to Related Parties - DHH | 169,835 | 169,835 | - |
| **Total Liabilities** | **61,379,385** | **65,030,480** | **(3,651,096)** |
| **Net assets:** | | | |
| Unrestricted - UVMMC | 687,160 | 687,160 | - |
| Unrestricted - DHH | 687,160 | 687,160 | - |
| Current Year Profit to Date | 4,583,967 | 4,412,012 | 171,955 |
| **Total net assets** | **5,958,287** | **5,786,332** | 171,955 |
| **TOTAL LIABILITIES AND NET ASSETS** | **67,337,672** | **70,816,813** | **(3,479,141)** |

## OneCare Vermont

*Surplus & Loss Statement*

YTD July 2019

| | Annual Budget | YTD Budget | YTD Prior Month | Current Month | YTD | YTD Budget/Actual Variance |
|---|---|---|---|---|---|---|
| Medicaid Admin - $6.50 PMPM | $ 5,570,683 | $ 3,249,565 | $ 2,816,639 | 444,470 | $ 3,261,109 | $ 11,543 |
| Medicaid Complex Care Coordination | $ 5,500,000 | $ 3,208,333 | $ 2,478,420 | 399,495 | $ 2,877,915 | $ (330,418) |
| BCBS QHP PHM $3.25 PMPM | $ 664,677 | $ 387,728 | $ 560,944 | 58,916 | $ 619,860 | $ 232,131 |
| BCBS ASO PHM $3.25 PMPM | $ 585,000 | $ 341,250 | $ 195,244 | 191,292 | $ 386,536 | $ 45,286 |
| SF PHM $3.25 PMPM | $ 526,140 | $ 306,915 | $ - | - | $ - | $ (306,915) |
| Medicare Shared Savings/Blueprint | $ 8,021,268 | $ 4,679,073 | $ 3,171,118 | 528,520 | $ 3,699,638 | $ (979,435) |
| Primary Prevention | $ 1,100,000 | $ 641,667 | $ 550,000 | 91,667 | $ 641,667 | $ 0 |
| Informatics Infrastructure Support | $ 4,250,000 | $ 2,479,167 | $ 2,125,000 | 354,167 | $ 2,479,167 | $ 0 |
| Misc. Revenue | $ - | $ - | $ 57,134 | 2,907 | $ 60,041.18 | $ 60,041 |
| | | | $ - | | | |
| Participation Fees | $ 29,266,751 | $ 17,072,271 | $ 14,835,474 | 2,479,789 | $ 17,315,263 | $ 242,991 |
| | | | | | | $ - |
| **Total Income** | **$ 55,484,518** | **$ 32,365,969** | **$ 26,789,972** | **4,551,221** | **$ 31,341,193** | **$ (1,024,776)** |
| **PHM Expense:** | | | | | | |
| Population Health Management Program | $ 5,638,685 | $ 3,289,233 | $ 3,349,034 | 614,258 | $ 3,963,293 | $ 674,060 |
| Complex Care Coordination Program | $ 9,651,694 | $ 5,630,155 | $ 4,139,185 | 1,098,366 | $ 5,237,551 | $ (392,604) |
| CPR Program Cost | $ 2,250,000 | $ 1,312,500 | $ 704,936 | 98,253 | $ 803,189 | $ (509,311) |
| Value-Based Incentive Fund | $ 7,852,589 | $ 4,580,677 | $ 3,444,765 | 596,240 | $ 4,041,004 | $ (539,673) |
| Primary Prevention Programs | $ 910,720 | $ 531,253 | $ 336,681 | 45,285 | $ 381,965.18 | $ (149,288) |
| Specialist Program Pilot | $ 2,000,000 | $ 1,166,667 | $ - | - | $ - | $ (1,166,667) |
| Innovation Fund | $ 1,000,000 | $ 583,333 | $ - | - | $ - | $ (583,333) |
| RCR | $ 375,000 | $ 218,750 | $ 202,341 | 73,045 | $ 275,386 | $ 56,636 |
| PCMH Legacy Payments - Blueprint | $ 1,865,544 | $ 1,088,234.00 | $ 930,764 | 153,178 | $ 1,083,942 | $ (4,292) |
| CHT Block Payment - Blueprint | $ 2,321,670 | $ 1,354,307.21 | $ 1,160,835 | 193,472 | $ 1,354,307 | $ 0 |
| SASH- Blueprint | $ 3,834,054 | $ 2,236,531.50 | $ 1,932,027 | 330,338 | $ 2,262,365 | $ 25,833 |
| **Operating Expense:** | | | | | | |
| Salaries/Fringe | $ 8,404,320 | $ 4,902,520 | $ 3,101,435 | 615,549 | $ 3,716,984 | $ (1,185,536) |
| Purchased Services | $ - | $ - | $ 926,254 | 228,431 | $ 1,154,685 | $ 1,154,685 |
| Contract & Maintenance | $ 2,899,264 | $ 1,691,237 | $ 278,486 | 1,640 | $ 280,126 | $ (1,411,111) |
| Lease & Rental | $ 397,795 | $ 232,047 | $ 152,185 | 25,364 | $ 177,549 | $ (54,498) |
| Utilities | $ - | $ - | $ 19,038 | 5,177 | $ 24,215 | $ 24,215 |
| Other Expenses | $ 3,983,184 | $ 2,323,524 | $ 1,699,995 | 300,671 | $ 2,000,666 | $ (322,858) |
| **Total Expenses** | **$ 53,384,518** | **$ 31,140,969** | **$ 22,377,960** | **4,379,267** | **$ 26,757,226** | **$ (4,383,743)** |
| **Net Income / (Loss)** | **$ 2,100,000** | **$ 1,225,000** | **$ 4,412,012** * | **171,955** | **$ 4,583,967** | **$ 3,358,967** |

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**CMO Corner – Norman Ward, MD – September 17, 2019**

1. **Vermont Legislature - Act 17 of 2019 - An act relating to determining the proportion of health care spending allocated to primary care. –** Dr. Ward participates in this Green Mountain Care Board led workgroup with representatives from Vermont Medicaid, Blue Cross, Health Care Advocate, Vermont Association of Hospitals and Health Systems, Vermont Medical Society, Vermont Blueprint, Bi-State Primary Care, Vermont Care Partners, Planned Parenthood, and MVP. The primary focus to date has centered on determining an agreed to definition of primary care service codes, provider types, and non-claims based payments to permit the calculation of percent expenditures to primary care. The final report to the legislature will likely lead to comparisons to other states' experience and influence Vermont health policy decisions regarding primary care funding. Absence of data from the Vermont Health Care Uniform Reporting Evaluation System (VHCURES), ERISA self-insured employers, uninsured, and federal insurance health plans pose potential issues for the accuracy of the analysis.

2. **Dental Access and Reimbursement Workgroup** – Dr. Ward is attending this DVHA sponsored workgroup tasked with making recommendations to the Legislature on preventive and restorative dental service benefits and fees for Vermont Medicaid recipients. OneCare will need to consider whether or how to include dental services in our total cost of care for the Medicaid program.

   **Working Group Objectives**:

- *Evaluate current Medicaid reimbursement rates to dentists, dental therapists, and other providers of dental services and determine the amount of fiscally responsible increases to the rates for specific services that would be needed to attract additional providers to participate in the Vermont Medicaid program;*
- *Explore opportunities to further expand access to dental care in Vermont, including teledentistry services and integration of dental services into the scope of services provided through accountable care organizations;*
- *Determine the feasibility of, and costs associated with, establishing a State dental assistance program to provide access to affordable dental services for Vermont residents who have lower income and are enrolled in Medicare.*

3. **CMS Cross-Model ACO Face-to-Face Meeting – September 5-6, 2019, Washington DC –** Dr. Ward, Sara Barry, and Spenser Weppler attended this Next Generation ACO – End Stage Renal Disease ACO face-to-face conference. CMS presentations from Adam Boehler (outgoing head of Center for Medicare and Medicaid Innovation) and other CMS staff make it clear that the current administration continues to focus heavily on advancing existing and new value-based care models for Medicare that link quality to cost, shift financial risk onto providers of care, and puts emphasis on primary care. The newest model – Direct Contracting – incorporates elements of existing ACO programs (MSSP, NGACO, CPC+). Some 1000 entities have submitted requests for information to potentially enroll in the new model. Sara Barry also facilitated a workgroup session around creating culture change among providers and healthcare executives in promoting the shift to value based care. The session was well attended.

4. **Lifestyle Medicine Grand Rounds WebEx –** September 10, 2019 – Dr. Fontaine from Northwest Medical Center, Lindsey Hoar, RD and certified health coach, and two patients shared experiences and results of their interactions with the innovative Lifestyle Medicine Clinic at NWMC. The use of health coaches to improve tangible health outcomes (weight control, overall wellbeing, diabetes control, pre-operative health optimization.) The training and certification criteria for health coaches was reviewed as well as billing methods and motivational techniques.

| Policy Number & Title: | 2020 Comprehensive Payment Reform Policy |
|---|---|
| Responsible Department/s: | ACO Finance, Clinical and Quality, and Operations |
| Author: | |
| Date Implemented: | 1/1/2020 |
| Date Reviewed/Revised: | |
| Next Review Date: | 12/2020 |

**Purpose:** A policy for calculating, distributing and/or suspending the 2020 Comprehensive Payment Reform (CPR) Program payments to participating CPR Independent Primary Care Organizations in accordance with OneCare Vermont's (OneCare) Clinical Model.

**Policy Statement:** The Comprehensive Payment Reform Policy describes the process by which eligible OneCare Independent Primary Care Organizations are paid by OneCare for performing activities outlined in the OneCare Program of Payment and Comprehensive Payment Reform (CPR) Program Amendment.

**Definitions:**
CPR Program refers to an optional program for independent primary care to participate in clinical innovation through payment reform. Payer programs included are Vermont Medicare ACO Initiative (Medicare), Vermont Medicaid Next Generation ACO Program (Medicaid) and Blue Cross Blue Shield of Vermont Next Generation Model ACO Program (BCBSVT QHP).

Care Coordination refers to the deliberate organization of patient care activities and sharing of information among all of the Participants, Preferred Providers or Collaborators concerned with a patient's care with the goal of achieving safer and more effective care. The patient's needs and preferences are known and communicated at the right time to the right people and used to provide safe and effective care.

Care Managed refers to having a Lead Care Coordinator, identified by the patient, and a Shared Care Plan documented in Care Navigator or other OneCare approved software system. The Shared Care Plan should be routinely reviewed by the Lead Care Coordinator with the patient and appropriate Care Team members and updated as needed.

Core Codes refers to the set of procedure codes that are standard across all CPR practices and are subject to risk adjustment.

Non-Core Codes refers to all other procedure codes not considered to be a Core Code. Non-Core Codes are practice-specific and are not risk-adjusted.

Per Member Per Month (PMPM) Payment refers to the monthly fixed payment made by OneCare to CPR Organizations for Attributed Lives.

Variable Payment refers to the supplemental funding OneCare provides to CPR practices that is designed to be above and beyond the calculated PMPM fee-for-service (FFS) equivalent. The actual earned amount of the Variable Payment is dependent upon performance in care coordination and care delivery optimization described in this policy and/or in the CPR Program Amendment.

**Actions/Responsibilities:**

CPR Organizations will be paid a per member per month (PMPM) payment for their adult attributed lives and a PMPM payment for their pediatric attributed lives that replaces: the FFS that would be otherwise paid for any OneCare lives receiving care in their practice(s), the OneCare Population Health Management Payment, the Supplemental Care Coordination Payments, and the Variable Payment defined above. Supplemental Payments for Care Conferences are not included in the CPR PMPM and will be paid separately. (Note: the ability to replace FFS with the PMPM is dependent on the Payer offering this option. If the Payer does not offer this option the Participant will continue to receive FFS and the PMPM will be adjusted accordingly.)

Each of the PMPM payments will be comprised of a component for Core Codes and a component for Non-Core Codes. The Core Code component will be risk-adjusted for the adult population, and the Core Code component for pediatric population will be age/gender adjusted. The Non-Core Code component will be practice-specific and will not be adjusted other than for factors such as regular inflation.

Of the aggregate PMPMs for the adult and pediatric populations, 15% will be a Variable Payment. The amount of this 15% variable component that will be paid will be dependent on performance in two key areas: Care Coordination Engagement and Care Delivery Outcomes. The Variable Payment will be calculated separately for adult and pediatric populations, and updated as frequently as monthly to reflect current performance outcomes.

To earn the full Variable Payment from OneCare, CPR Participants must meet the requirements below:

1. **Care Coordination Engagement (50% of the overall Variable Payment)**

   Care Coordination Engagement will be measured at the Practice site-level. The OneCare Care Coordination model aims to have 15% of the High and Very High Risk Attributed Lives actively Care Managed. For the period of January through March 2020, CPR Practice sites will receive full credit for the Care Coordination Engagement factor. Beginning April 1, 2020, the following methodology will apply:

   - Achieving 15% Care Managed for the CPR Practice's High and Very High Risk Attributed Lives will earn a 1.0 multiplier (i.e. full credit).
   - Achieving 0% Care Managed for the CPR Practice's High and Very High Risk Attributed Lives that attribute to the practice will earn a 0.0 multiplier (i.e. no credit).
   - All ratios within will be calculated by dividing the actual percent engaged by the target of 15%.
     - The multiplier will never exceed 1.0.

2. **Care Delivery Outcomes – (50% of the overall Variable Payment)**

   OneCare's Clinical Model is based on building and sustaining strong relationships between patients and their primary care providers as the backbone of the medical home neighborhood. Care Delivery Outcomes will be measured at the CPR Practice site-level and the following metrics will be used to assess the relationships:

   - PCP engagement (Weight 40%)
     - Achieve and maintain 90% of Attributed Lives (all payer blended) with a QE&M code billed from the CPR Practice in a rolling 12 month period.
   - Annual Wellness Visits (Weight 40%)
     - Achieve and maintain ≥ 40% Medicare Annual Wellness Visits for Attributed Lives in the Medicare Program in a rolling 12 month period.
     - Achieve and maintain ≥ 67% Adolescent Well Visits for adolescent Attributed Lives (blended across Medicaid and BCBSVT QHP) in a rolling 12 month period.
   - Care for Special Populations (Weight 20%)
     - Adults: Demonstrate 75% of the CPR Practice's Attributed Lives with Hypertension are in

control by providing OneCare with a summary panel management report from the CPR Practice(s) each quarter demonstrating compliance. The definition for this panel report includes all patients in a practice 18-85 years with a diagnosis of hypertension whose blood pressure was adequately controlled as evidenced by at least one BP reading <140/90 mm HG among the last three BP readings recorded by the practice in the past 12 months.

OR

- Children: Achieve and maintain ≥ 70% of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the first three years of life.

- For each metric, meeting or exceeding the target will result in a 1.0 multiplier for the particular segment.
  - If the target is not met, partial credit will be earned by dividing the actual performance by the target to calculate the multiplier.

OneCare may alter these targets by mutual agreement with the CPR Organization during the course of the Performance Year.

Payments will be made monthly to CPR Organizations through ACH transfer. In the event that critical data are not available at any point throughout the Performance Year, OneCare will make payments based on the best estimates available to ensure sustained cash flow for the CPR Organizations. Any estimates will be subject to reconciliation upon receipt of the necessary information.

**References:**

**Monitoring Plan:** The Finance department staff is charged with monitoring accuracy and timeliness of payments. The Clinical and Quality department staff is charged with monitoring performance against the Variable Payment components on an ongoing basis and will report findings through the CMO and Population Health Strategy Committee.

**Related Policies/Procedures:**
OneCare Advanced Community Care Coordination Payments Policy

**Location on Shared Drive:** S:\Groups\Managed Care Ops\OneCare Vermont\Policy and Procedures\Policies\Current Policies

**Management Approval:**

| | |
|---|---|
| Director, Finance and Analysis | Date |
| Senior Director, Value Based Care | Date |
| Chief Executive Officer | Date |
| Chair, OneCare Board of Managers (Required) | Date |

| Policy Number & Title: | 03-05 Data Transparency |
|---|---|
| Responsible Department/s: | Clinical, Analytics, Quality, Finance, Operations, Compliance |
| Author: | Sara Barry |
| Date Implemented: | 09/17/2019 |
| Date Reviewed/Revised: | |
| Next Review Date: | 09/01/2020 |

## I. PURPOSE

The purpose of this Data Transparency Policy ("Policy") is to describe OneCare Vermont's (OneCare) data transparency standards in relationship to sharing of data within the ACO Network for the purpose of ACO Activities. This Policy operates in connection with OneCare's "Data Use" and "Privacy and Security" Policies and must be reviewed to ensure all standards for the use and disclosure of data are maintained.

## II. SCOPE

This policy applies to all members of OneCare's workforce, Board Members, committee members and the ACO Network (Participants, Preferred Providers and Collaborators – collectively ACO Network) and pertains to all data shared outside the of OneCare via self-service applications, standard reporting, and ad hoc data requests.

## III. POLICY STATEMENT

It is the policy of OneCare to share data with the ACO Network to support ACO Activities. All members of the ACO Network who receive data from OneCare must comply with all regulatory and payer requirements as well as OneCare's policies and procedures. OneCare's data transparency guiding principles include:

1. The ACO Network's effective performance of ACO Activities depends on sufficient access to data;
2. The ACO Network's understanding of and ability to address variations in utilization, quality, cost, and satisfaction (including the ability to outreach to top performers for advice and recommendations on change effort) depends on sufficient access to data;
3. The ACO Network will be motivated to change through access to comparative data; and
4. Healthcare delivery and patient outcomes can be enhanced by open sharing of data.

OneCare management shall use discretion in determining what data to share while ensuring compliance with all regulatory and payer requirements and OneCare policies and procedures.

## IV. DEFINITIONS

**"Accountable Care Organization (ACO)"** refers to a group of doctors, hospitals, and/or other health care providers, who come together voluntarily to provide coordinated high-quality care to the beneficiaries and members they serve.

**"ACO Activities"** refers to activities engaged in by OneCare related to promoting accountability for the quality, cost, and overall care for a population of beneficiaries and members attributed to OneCare under the terms of any ACO Program agreement(s) between OneCare and any Payer(s), including managing and coordinating care; encouraging investment in infrastructure and redesigned care processes for high quality and efficient service delivery; or carrying out any other obligation or duty of OneCare.

**"ACO Network"** refers to all OneCare contracted Participants, Preferred Providers, and/or Collaborators.

**"Aggregate Data"** refers to data that is compiled and summarized by grouping (e.g. Provider, Practice Site, TIN, HSA, and/or Payer).

**"Collaborator"** refers to a Subcontractor that has entered into a Collaborator Agreement, a Business Associate Agreement (BAA), and a Data Use Agreement (DUA) with OneCare to perform any ACO Activities on behalf of OneCare.

**"Health Service Area (HSA)"** refers to one or more counties that are relatively self-contained with respect to the provision of routine hospital care as defined by the Dartmouth Atlas methodology.

**"Participant and Preferred Provider"** refer to health care provider(s) that have entered into a Participant or Preferred Provider Agreement(s) with OneCare to participate in one or more ACO Programs.

**"Payer"** refers to any governmental or commercial entity contracted with OneCare to provide ACO Services to its beneficiaries or members as part of an ACO Program.

**"Risk Bearing Hospitals"** refers to hospitals contracted with OneCare that take financial accountability (i.e. risk) for the services provided to beneficiaries assigned to their health service area.

**"TIN"** means Federal Taxpayer Identification Number or employer identification number or social security number in the case of a provider who bills Payers under his/her social security number.

## V. ACTIONS

1. OneCare will provide Risk Bearing Hospitals with access to data at the HSA, TIN, Practice Site, Provider, and/or patient-level for beneficiaries attributed to their l HSA so that these Risk Bearing Hospitals may more effectively monitor and perform ACO Activities.
2. OneCare has the capacity to share Payer, HSA, TIN, Practice Site, and/or Provider level data (derived from claims and clinical information) within OneCare's Network to support initiatives to improve quality, contain costs, and manage utilization. OneCare's Utilization Review Committee will review and approve requests to share data in support of these initiatives by members of the ACO Network (whether all-network programs or specific ad hoc analysis) consistent with applicable policies and resources available to fulfill requests.
3. OneCare will not share Payer, HSA, TIN, Practice Site, Provider, and/or Patient level data outside of the ACO Network unless it complies with OneCare's regulatory and contractual obligations. In the case of such a request from an ACO Network Participant, it will be reviewed by OneCare's management team, including legal and compliance before such a release of data is made.

## VI. OVERSIGHT AND ENFORCEMENT

OneCare management is responsible for the oversight and enforcement of this Policy. OneCare Workforce members that violate this policy may be subject to sanctions, which can include dismissal or termination of access to data. Participants or Preferred Providers that violate this Policy may also be subject to sanctions, which can include limitation of access to data, penalties or termination of ACO Networks participant's status with OneCare and may be required to follow remedial provisions in law, regulation or Data Use Agreements).

## VII. REFERENCES

1. OneCare Data Use and Privacy & Security Policies
2. Federal regulations (e.g. HIPAA, The Privacy Act of 1974, HITECH)
3. Payer Contracts & Data Use Agreements
4. Business Associate and Qualified Service Organization Agreements
5. Participant, Preferred Provider, and Collaborator Agreements

**Location on Shared Drive:** S:\Groups\Managed Care Ops\OneCare Vermont\Policy and Procedures\Policies
**Management Approval:**

Senior Director, Value Based Care Date

Chief Operating Officer (COO) Date

**Board of Managers Approval:** *Requires BOM approval annually if content/substantial changes. If N/A BOM approval every two years.

Chair, OneCare VT Board of Managers Date

OneCare Vermont

| Policy Number & Title: | 03-03 OneCare Data Use Policy |
|---|---|
| Responsible Department/s: | Analytics |
| Author: | Sara Barry |
| Date Implemented: | 6/18/15 |
| Date Reviewed/Revised: | 09/05/19 |
| Next Review Date: | 09/01/20 |

## I. PURPOSE

OneCare Vermont ("OneCare") is an accountable care organization contracted with state and federal agencies, commercial health plans, and third-party administrators, to administer value-based payment programs and perform Accountable Care Organization Activities.

So that it may perform these functions, Payers, Participants and Preferred Providers share various types of data with OneCare. OneCare analyzes these data and uses it to promote accountability for patient populations, improve care coordination among ACO Participants, Preferred Providers, Collaborators and their patients, and encourage investment in infrastructure and redesign of the care processes to achieve high quality and efficient delivery of services.

OneCare's Participants and Preferred Providers have designated themselves an organized health care arrangement ("OHCA") for the purpose of facilitating the use and disclosure of protected health information ("PHI") among them for treatment and health care operations purposes, or as otherwise permitted under the HIPAA Privacy Rule.

The purpose of this Data Use Policy ("Policy") is to provide standards and guidance to OneCare's Board of Managers and Workforce, Participants, Preferred Providers, Collaborators, Regional Clinician Representatives, Subcontractors, and Vendors regarding the appropriate ways to use or disclose data provided to OneCare. This Policy, together with OneCare's Privacy and Security Policy, is designed to ensure that OneCare manages data in accordance with the HIPAA Privacy Rule, its contractual obligations with Payers, and any applicable privacy laws.

## II. POLICY STATEMENT

It is the policy of OneCare, as a Business Associate of its Participants and Preferred Providers, and as a custodian of Payer data, to ensure that in using and disclosing data it protects the privacy of individual health information in accordance with its contractual obligations and applicable privacy laws. OneCare's Board of Managers, Workforce, Participants, Preferred Providers, Collaborators, Regional Clinician Representatives, Subcontractors, and Vendors are required to comply with this policy when accessing or using data in OneCare's possession.

## III. DEFINITIONS

"**Accountable Care Organization" (ACO)** refers to a group of doctors, hospitals, and/or other health care providers, who come together voluntarily to provide coordinated high-quality care to the beneficiaries and members they serve.

"**ACO Activities**" refers to activities engaged in by OneCare related to promoting accountability for the quality, cost, and overall care for a population of beneficiaries and members attributed to OneCare under the terms of any ACO Program agreement(s) between OneCare and any Payer(s), including managing and coordinating care; encouraging investment in infrastructure and redesigned care processes for high quality and efficient service delivery; or carrying out any other obligation or duty of OneCare.

"**ACO Program**" refers to any value-based payment arrangement between OneCare and a Payer for the provision of ACO Services to the Payer's beneficiaries or members, as well as any other services it may provide to the Payer.

"**ACO Program Agreement**" refers to an agreement between OneCare and a Payer for the performance of ACO Services and any other services it may provide to the Payer.

**"ACO Services"** refers to health care services provided by OneCare to a Payer's beneficiaries and members under an ACO Program Agreement.

"**Business Associate**" refers to a person or organization, other than a member of a covered entity's workforce, that performs certain functions or activities on behalf of, or provides certain services to, a covered entity that involve the use or disclosure of individually identifiable health information. Business associate functions or activities *performed on behalf of* a covered entity include *claims processing, data analysis, utilization review, and billing*. Business associate services *rendered to* a covered entity are limited to *legal, actuarial, accounting, and consulting, data aggregation, management, administrative, accreditation, or financial services*.

"**Collaborator**" refers to a Subcontractor that has entered into a Collaborator Agreement, a Business Associate Agreement (BAA), and a Data Use Agreement (DUA) with OneCare to perform any ACO Activities on behalf of OneCare.

"**Commercial Claims Data**" refers to claims-reimbursement data provided to OneCare by a commercial Payer that is described in an ACO Program Agreement and/or DUA. Commercial Claims Data includes claims-level detail, PHI Data, and may include Commercial Proprietary Data.

"**Commercial Proprietary Data**" refers to data provided to OneCare by a commercial Payer in relation to an ACO Program that is described as proprietary or confidential in an ACO Program Agreement and is subject to a confidentiality agreement and/or a DUA. Commercial Proprietary Data generally relates to, reveals, or could be used to deduce with reasonable effort, provider-specific financial or reimbursement terms. For example, data concerning payments or negotiated rates between a commercial Payer and a health care provider participating in the Payer's provider network are generally considered to be Commercial Proprietary Data. The use of Commercial Proprietary data will be governed by a DUA and/or an ACO Program Agreement.

**"Community Collaborative"** refers to a gathering of local stakeholders working collaboratively to improve the care of the population in their health service area.

**"Data"** refers to health data of individuals provided to OneCare in electronic form by Payers, Participants, Preferred Providers, or any other covered entity - as that term is defined in 45 CFR 160.103 – related to health conditions, reproductive outcomes, causes of death, and quality of life of an individual, typically including record(s) of services received, conditions of those services, and clinical outcomes or information concerning those services, as well as demographic and other identifying information. Data further refers to all forms of Data defined in this Policy.

**"Data Use Agreement" (DUA)** refers to an agreement between OneCare and a Payer that governs the permitted uses of Data provided by a Payer to OneCare in relation to an ACO Program.

"**Government Claims Data**" refers to certain beneficiary-identifiable claims data provided to OneCare by Medicaid, Medicare, or any other federal healthcare program contracted with OneCare to provide ACO Services to its beneficiaries. Government Claims Data includes claims-level detail and PHI Data.

**"Health Information Exchange" (HIE) –** refers to the centralized repository or data warehouse operated by **VITL** that holds health information contributed by participating health care organizations in trust, and ensures that it is accessible by only authorized users.

"**Minimum Necessary Standard**" requires covered entities to take reasonable steps to limit the use or disclosure of, and requests for, protected health information to the minimum necessary to accomplish the intended purpose. It does not apply to the following:

- Disclosures or requests by a health care provider for treatment purposes.
- Disclosures to the individual who is the subject of the information.
- Uses or disclosures made pursuant to an individual's authorization.
- Uses or disclosures required for compliance with the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Rules.
- Disclosures to the Department of Health and Human Services when disclosure of information is required under the HIPAA Privacy Rule for Enforcement purposes.
- Uses or disclosures that are required by other law.

"**Organized Health Care Arrangement**" **(OHCA)** refers to a clinically-integrated care arrangement of covered entities as defined in 45 C.F.R. § 160.103 in which individuals typically receive healthcare from more than one provider and in which the participants present themselves to the public as part of a joint arrangement. An accountable care organization qualifies as a clinically-integrated care arrangement of covered entities for the purpose of designating an OHCA.

"**OHCA Members**" refers to covered entities who designate themselves as participants in an OHCA.

"**Participant**" and "**Preferred Provider**" refer to health care provider(s) that have entered into a Participant or Preferred Provider Agreement(s) with OneCare to participate in one or more ACO Programs.

"**Participant Aggregate Data**" refers to data provided to OneCare by a Participant or Preferred Provider in aggregate form that does not include PHI Data.

"**Participant Data**" refers to data provided to OneCare by a Participant or Preferred Provider that includes PHI Data.

"**Payer**" refers to any governmental or commercial entity contracted with OneCare to provide ACO Services to its beneficiaries or members as part of an ACO Program.

"**Payer Aggregate Data**" refers to data provided to OneCare by a Payer in aggregate form that does not include claims-level detail, PHI Data, or Commercial Proprietary Data.

"**PHI Data**" refers to data provided to OneCare by a Payer, Participant, or Preferred Provider that includes individually-identifiable "Protected Health Information" (PHI), as that term is defined under the HIPAA Privacy Rule, that with or without direct identifiers can be used, either by itself or in combination with other data, to deduce an individual's identity. Examples of PHI Data include a person's: geographic location, age if greater than 89, sex, diagnosis and/or procedure(s), admission and/or discharge dates, and/or date of death.

**"Provider Portal" (Portal)** refers to a secure software platform provided by OneCare that allows Participants and Preferred Providers to remotely access data relevant to the performance of ACO Services and other ACO Program obligations.

"**Regional Clinician Representatives**" refers to clinicians contracted with OneCare to provide guidance to Community Collaboratives and to support OneCare in performing ACO Activities in OneCare's Service Areas.

"**Service Area"** refers to counties identified by OneCare in which Participants or Preferred Providers who are Primary Care Specialists have office locations, as well as the adjacent counties.

"**Subcontractor**" refers to a person or entity that contracts with OneCare to perform part or all of an obligation(s) OneCare has agreed to perform under the terms of an ACO Program Agreement, or OneCare is required to perform pursuant to any relevant state or federal statute, regulation, rule, or controlling guidance.

**"Vendor"** refers to a person or entity that contracts with OneCare to provide it with goods and/or services.

"**VAPAM**" refers to the Vermont Medicare ACO Initiative Program.

**"VITL"** refers to Vermont Information Technology Leaders, Inc. which is the independent, non-profit organization that built and operates Vermont's statewide Health Information Exchange.

"**VMNG**" refers to the Vermont Medicaid Next Generation Program administered by the Department of Vermont Health Access.

"**Workforce**" refers to: person(s) employed by, leased or furnished to, or shared with OneCare to perform jobs it assigns to them.

**IV. DATA USES**

1. Uses of PHI Data. PHI Data may only be used/disclosed in accordance with the HIPAA Privacy Rule, including the Minimum Necessary Standard, and in accordance with this Section IV of the Policy.

2. Uses of Government Claims Data. Government Claims Data may be used by and/or disclosed by or to members of OneCare's Workforce, Member(s) of its Board of Managers, Participant(s), Preferred Provider(s), and/or Regional Clinical Representative(s) - including committees or subcommittees comprised of such persons - while engaged in the performance of: jobs assigned to them by OneCare, OneCare's obligations under an ACO Program Agreement, or other ACO Activities in accordance with the HIPAA Privacy Rule, the Minimum Necessary Standard, and the terms of any applicable DUA or ACO Program Agreement. Government Claims Data may not be disclosed to any other person(s).

3. Uses of Commercial Claims Data. Commercial Claims Data may only be used by and disclosed by or to members of OneCare's Workforce in accordance with the terms of a DUA or ACO Program Agreement and in accordance with the HIPAA Privacy Rule, including the Minimum Necessary Standard. Commercial Claims Data may not be disclosed to Member(s) of OneCare's Board of Managers, Subcontractors, Vendors, or other person(s) unless such disclosure is permitted by the Commercial Payer's DUA. Commercial Claims Data may not be shared with Participants, Preferred Providers, Collaborators, Regional Clinician Representatives, or Community Collaboratives unless permitted by the Commercial Payer's DUA.

4. Uses of Payer Aggregate Data. Payer Aggregate Data may be used by OneCare for ACO Activities, including sharing such information with the public, in accordance with the HIPAA Privacy Rule and the terms of any applicable DUA or ACO Program Agreement.

5. Uses of Participant Data. Participant Data may only be used by and disclosed by or to members of OneCare's Workforce, Participant(s), Preferred Provider(s), Subcontractor(s), Vendor(s),

Collaborator(s), or Regional Clinician Representative(s) that have entered into a Business Associate Agreement with OneCare, and in accordance with the HIPAA Privacy Rule, including the Minimum Necessary Standard. Participant Data may be used by OneCare to create Participant Aggregate Data. Participant Data may not be released to the Community Collaboratives.

6. Uses of Participant Aggregate Data. Participant Aggregate Data may be used and disclosed for ACO Activities in accordance with the HIPAA Privacy Rule.

7. Uses of Combined Data. Any combination of Payer or Participant data must adhere to Sections 1 through 6 of this Article IV based on the type of data. Where data from multiple Payers is aggregated, the most restrictive use applicable to any individual type of data contained in the combined data as set forth in any applicable DUA or ACO Program Agreement should be followed.

8. Accessing and Using the Provider Portal. OneCare grants Participants, Preferred Providers, and Collaborators – including their employees authorized to use the Portal by OneCare – (collectively "Users") certain privileges to access the Portal in accordance with the terms of their Participant ,Preferred Provider, or Collaborator Agreement(s), this Policy, the HIPAA Privacy Rule, including the Minimum Necessary Standard, and other relevant OneCare policies and procedures. Users may not re-disclose data obtained from OneCare through the Portal.

9. Data Obtained from the VITL HIE. OneCare contracts with VITL as its Business Associate to provide certain data collection, storage, and exchange services as an HIE. Data provided to OneCare by VITL will fall under one or more of the definitions set forth in this Policy and shall be used in accordance with terms of this Policy.

10. Releasing Data to Analytics Vendor(s). OneCare may release data provided by Payers to Subcontractor(s) and Vendor(s) performing data analytics services (Analytics Vendors) in accordance with the terms of any applicable DUA or ACO Program Agreement, this Policy, and the HIPAA Privacy Rule, including the Minimum Necessary Standard. OneCare will work with its Analytics Vendors to ensure they store and manage any data provided by OneCare in accordance with the terms of any service agreement and BAA with OneCare, any applicable DUA or ACO Program Agreement that contemplates such data, any separate permissions received by the Analytics Vendor from any Payer, any relevant OneCare policies and procedures, and the HIPAA Privacy and Security Rules.

## V. OVERSIGHT AND ENFORCEMENT

OneCare management is responsible for the oversight and enforcement of this Policy. OneCare Workforce members that violate this policy may be subject to sanctions, which can include dismissal or termination of access to data. Participants or Preferred Providers that violate this Policy may also be subject to sanctions, which can include termination of participation agreements with OneCare.

**Location on Shared Drive:** S:\Groups\Managed Care Ops\OneCare Vermont\Policy and Procedures\Policies
**Management Approval:**

Senior Director, Value Based Care Date

Chief Compliance Officer Date

Chief Operating Officer (COO) Date

**Board of Managers Approval:** *Requires BOM approval annually if content/substantial changes. If N/A BOM approval every two years.

Chairman, OneCare VT Board of Managers Date

OneCare Vermont

| Policy Number & Title: | 06-14 Compliance Policy |
|---|---|
| Responsible Department/s: | Compliance |
| Author: | Gregory Daniels |
| Original Implementation Date | September 23, 2013 |
| Date Reviewed/Revised: | September 1, 2019 |
| Next Review Date: | September 1, 2020 |

## I. Purpose

This document sets forth the elements of the Compliance Policy for the OneCare Vermont, ("OneCare"), a Limited Liability Corporation ("LLC") formed to: (i) participate in cost savings and other arrangements with government programs, commercial insurers and other payers; (ii) develop a network of health care providers for the delivery of health care services according to applicable rules, regulations and contractual obligations for the purpose of improving the quality and efficiency of health care and the patient care experience; (iii) promote evidence-based medicine, patient engagement, reporting on quality and cost, and care coordination and distribution of shared savings, and (iv) engage in other similar or related activities.

This Compliance Policy is created to ensure OneCare abides by applicable federal, state and local laws, rules, and regulations in its formation and operation and creates a structure whereby the organization sets high ethical standards, consistently trains its workforce in those standards, audits and monitors for compliance with law and established standards, provides way for members and their employees/agents to report possible violations of law or this Plan, investigates reported non-compliance, and remedies noncompliance.

This Compliance Policy incorporates the statutes, regulations, and rules related to the formation and operation of an accountable care organization ("ACO") the terms and conditions set forth in the Vermont All-Payer Accountable Care Organization Model Agreement ("Agreement") between the Centers for Medicare and Medicaid Services ("CMS"), the Governor of the State of Vermont, the Green Mountain Care Board ("GMCB"), and the Vermont Agency for Human Services ("AHS") (collectively referred to as the "Parties"), and all related contracts between the parties in furtherance of the Agreement.

In the conduct of its business, OneCare and its Network shall comply with all applicable laws, including, but not limited to: (a) federal criminal law; (b) the False Claims Act (31 U.S.C. 3729 *et seq*.); (c) the anti-kickback statute (42 U.S.C. 1320a–7b(b)); (d) the civil monetary penalties law (42 U.S.C. 1320a–7a); (e) the physician self-referral law (42 U.S.C. 1395nn); and (f) federal and state antitrust laws (15 U.S.C. 1 *et seq*. and 10 M.R.S.A. § 1101-1102-A and 5 M.R.S.A. § 207, respectively).

## II. Statement

OneCare is committed to compliance with applicable federal, state and local laws, and regulations, including, without limitation, those governing publicly funded health care programs and ACOs, and those set forth by the GMCB; the ethical standards set forth in OneCare's Code of Conduct; the terms and conditions of any contractual agreement(s) with CMS, the State of Vermont through AHS, GMCB, or any other public or private payer.

This Compliance Policy is one aspect of the OneCare Compliance Program, which is modeled on the regulations governing ACOs and the terms of the Agreement, as well as guidance promulgated by the GMCB, anti-trust regulators and CMS related to the formation and operation of ACOs. This Compliance Policy outlines the organization of the program, including requirements for staff training, audit protocols, and reporting and investigation mechanisms. It is designed to promote full compliance with applicable law, and to ensure that any deviations from the law are promptly detected, investigated, and corrected.

## III. Scope

Applicable to all OneCare workforce and Network members.

## IV. Actions/Responsibilities

The OneCare Compliance Program will include the following elements:

### 1. Designated Compliance Official and Compliance Committee

The Compliance Officer shall report directly to the Board of Managers and the Chief Executive Officer ("CEO") of OneCare. The Compliance Officer shall be responsible for:

- Overseeing and monitoring OneCare's compliance activities, including the development and implementation of a Code of Conduct;
- Ensuring the effectiveness of the compliance program through auditing and monitoring;
- Ensuring alignment of the compliance program with applicable state and federal laws;
- Reporting periodically to the OneCare leadership team and the Board of Managers on compliance matters and advising OneCare on appropriate compliance policies and procedures, reporting probable violations of law,
- Repaying overpayments to the extent OneCare receives any payment for services, and other applicable compliance matters;
- Reviewing and revising elements of the Compliance Policy to address changes in regulatory requirements;
- Serving as a knowledgeable resource to organizational and operational matters relating to compliance;
- Developing and implementing a compliance education program for the OneCare Network;
- Receiving and investigating reports of potential non-compliance or other conduct that may violate applicable laws, regulations, policies or ethics; and
- Developing policies and procedures that encourage the reporting of non-compliance or suspected fraud, waste and abuse, and ensuring that those who do report may do so without fear of retaliation.

The Compliance Officer will not serve as legal counsel to OneCare.

The Compliance Committee will be comprised of OneCare staff to include the following: the Chief Operations Officer ("COO"), Chief Medical Officer ("CMO"), Directors for Value Based Care, and ACO Program Strategy and Development and/or their designees, and will be chaired by the Compliance Officer. The Committee will work with and provide input to the Compliance Officer in developing and periodically updating a detailed and effective Compliance Policy to identify, investigate and refer fraud, waste and abuse as set forth in Agreement requirements and for each payer program. The Committee will also, as an integral part of its work, monitor data from program payers as well as external data.

### 2. Code of Conduct

OneCare has established a Code of Conduct which is an essential component of the Compliance Program. The Code of Conduct establishes the general ethical and compliance expectations for OneCare employees and the OneCare Network of participants, preferred providers, collaborators, contractors, awardees, and

others who perform functions or ACO related activity services for or on behalf of OneCare. The Code of Conduct is available to the OneCare through electronic means or upon request.

**3. Policies and Procedures**

OneCare develops and maintains policies and procedures to ensure that the ACO business and operations are conducted in accordance with this Compliance Plan, the Code of Conduct, and all statutory and regulatory requirements. These policies and procedures are available to all OneCare employees through electronic means or upon request.

OneCare shall adopt policies and procedures to address the following compliance program functions:

i. Internal audit/monitoring policy to ensure compliance with this Policy and Code of Conduct;
ii. Polices addressing compliance with the fraud & abuse policy, including prohibitions found in federal and state criminal law, such as anti-kickback laws, stark laws, false claims act, referrals among ACO members, gainsharing CMP, and prohibitions on patient inducements;
iii. Policies addressing compliance with the requirements of the ACO Fraud and Abuse Waivers granted to OneCare by CMS under the Vermont All-Payer Model;
iv. Non-retaliation;
v. Prohibition on unlawful Referrals;
vi. Confidentiality of protected health information;
vii. Record retention and destruction (General 10-year retention period for ACO documents);
viii. Information Security/HIPAA Security Rule Compliance;
ix. Notification of breach of protected health information;
x. Reporting, investigating and correcting violations of the law or the Code of Conduct;
xi. Training and education

When an organization becomes a member of the OneCare Network, it shall provide copies of its written compliance plan and policies to the OneCare Compliance Officer. To the extent permitted by law, the Network member shall ensure its compliance plan and policies sufficient address legal and regulatory requirements related to ACO activities, and reflect the requirements of this Compliance Plan. OneCare Network members shall work collaboratively with the OneCare Compliance Officer to ensure its compliance plan and policies sufficiently address legal and regulatory requirements related to ACO activities.

**4. Education and Training**

The Compliance Officer shall provide annual training and make available educational resources and training materials either in-person or on-line to the OneCare Network to ensure compliance with the statutes and regulations applicable to the ACO and to individual healthcare provider entities. The OneCare Network and Board of Managers shall be educated, at a minimum, in the following areas:

- Physician self-referral, anti-kickback statutes and civil monetary penalties, including the application of CMS final waivers in connection with ACO start-up and ongoing operations (42 C.F.R. Chapter V), other fraud & abuse laws, federal and state criminal law related specifically to healthcare fraud, referrals among ACO members, gainsharing CMP, and prohibitions on patient inducements
- Use of the Compliance Hotline

- Anti-trust law and its application to ACOs
- ACO beneficiary rights
- ACO Marketing requirements
- Reporting and investigating suspected violations and complaints
- Non-retaliation `
- Conflict of interest requirements
- Data sharing, other information security requirements, Patient Confidentiality, and
- Record retention

Other education may be provided as necessary to address evolving compliance risks, including but not limited to items addressed in the federal Office of the Inspector General ("OIG") reports or identified during internal or external audits of OneCare or any of its participant organization. The Compliance Officer shall keep a record of education and training provided to the OneCare Network, and shall maintain documentation and attendance records of each training.

**5. Conflict of Interest**

OneCare has a conflict of interest policy that applies to members of the governing body and which requires annual and ongoing disclosures of relevant financial interests, a process for determining whether a conflict of interest exists, a process for addressing any conflicts that arise, and remedial steps that will be taken in the event members of the governing body fail to comply with the policy.

**6. Auditing and Monitoring**

OneCare maintains a program of periodic auditing and monitoring to assess risk and confirm compliance with applicable laws, rules and program agreements. This program will regularly review metrics related to cost, utilization, and quality for indications of program integrity concerns.

**7. Confidential Communications and Reporting**

OneCare maintains a confidential communication mechanism so that workforce members and others may report compliance concerns without concern for retaliation

A. Internal Reporting. OneCare workforce and its Network have an affirmative duty to report in good faith any known or suspected violations of applicable law or policy. These reports may be made to OneCare leadership or directly to the Compliance Officer. OneCare has established a Compliance Hotline, a toll-free telephone line, as a means to enable anyone to report instances of noncompliance and/or make inquiries on compliance issues. Information concerning the Hotline is publicized throughout the Network through the OneCare website and is included in education and training materials. Reports made to the Compliance Officer will be treated confidentially. Reports may be made anonymously.

   OneCare is committed to a policy of non-retaliation against workforce members and Network members who report suspected violations in good faith. Any action taken by an OneCare workforce member or Network member to retaliate against anyone making a good faith report alleging improper activities is strictly prohibited. Any workforce member or Network member who commits or condones any form of retaliation will be subject to discipline up to, and including, termination of employment or exclusion from OneCare.

B. External Reporting. If OneCare discovers credible evidence of misconduct from any source related to OneCare's operations and performance and, after a reasonable inquiry, believes that the misconduct represents a probable violation of law, OneCare will promptly report the existence of misconduct to the appropriate contracted program or law enforcement agency within the appropriate period.

**8. Monitoring of Network**

OneCare and its Network will not knowingly hire, employ or contract with an individual or entity that has excluded from participation in any federal health care program. All OneCare workforce members and Network members will be screened against the OIG List of Excluded Individuals and Entities ("OIG LEIE") and the U.S. General Services Administration's Excluded Parties List System ("GSA EPLS") prior to initial hire and periodically as needed thereafter. Subcontractors will be required to conduct such screenings and assure OneCare that no excluded or debarred individuals are employed. Documentation of such screening will be maintained by the Compliance Officer.

OneCare workforce and Network members will immediately notify OneCare of the identification of any person or entity who provides services to or on behalf of OneCare and its Network that (a) has been excluded according to the OIG LEIE or GSA EPLS; (b) has been subject to any conviction or adverse action that subjects the individual to federal health care program exclusion under 42 U.S.C. 1320a-7; or (c) has a history of health care program integrity issues.

OneCare will immediately remove any excluded entity or individual from any work related directly or indirectly to OneCare.

**9. Responding to Detected Compliance Issues**

OneCare commits to timely and full cooperation with governmental inquiries, audits and investigations, and the adherence to standards and protocols that involve OneCare's legal counsel, its Compliance Officer, as well as the Compliance Officers of OneCare's Network.

OneCare will take appropriate corrective action in response to any identified compliance issues. Such corrective action may include additional training, amended policies and procedures and/or employee discipline.

**10. Coordination with Regulators**

OneCare will work cooperatively with and maintain communication with payers and regulatory agencies, including program integrity units.

**11. Vermont All-Payer Model Program Integrity**

While OneCare participates in the Vermont All-Payer Model Program ("APM Program"), all program integrity requirements set forth in any program agreement between OneCare and the Department of Vermont Health Access (DVHA) shall be included as part of this Compliance Plan.

The Compliance Officer and OneCare will cooperate and maintain communication with DVHA's Program Integrity Unit to make prompt reports or referrals of fraud, waste, and abuse and will participate in the development of corrective action plans.

A. Phone Staff Training

OneCare Workforce members who staff member and provider services phone lines will be trained in the detection of potential fraud, waste, and abuse and the parameters for reporting any suspicions to the Compliance Officer.

B. Fraud and Abuse Waivers and Updates

The Board of Managers will, in accordance with the APM Program waiver requirements, review and approve all permitted waivers of law.

C. Monitoring Provision of Reports to DVHA

OneCare will monitor on a regular basis through its committees and Board of Managers reports relating to key metrics of cost, utilization, and quality to identify variance that may inform program integrity functions. The following type of reports will be monitored and made available to DVHA at its request: Over and Underutilization reports; HEDIS Measures; Payer required Quality Measures (CMS, Commercial, DVHA); Care Coordination Outcomes; Beneficiary/Member Experience; Medical Expense Targets; Member Services Grievance and Appeals and; Network reports.

On an annual basis OneCare will comprehensively evaluate Quality, Experience, Total Cost of Care, and Utilization outcomes to identify opportunities for improvement as well as accomplishments and will develop interventions based on the evaluation. The evaluation will include over and underutilization, appropriateness, efficacy or efficiency of services, and member satisfaction. The Population Health Strategy Committees will review the evaluation which will ultimately be approved by the Board of Managers and made available to DVHA.

**V. Outcome**

An effective compliance program.

**VI. Related Policies/Procedures**

Code of Conduct

**VII. Monitoring Plan**

This Compliance Policy and the Code of Conduct shall be reviewed periodically and updated to be consistent with the requirements established by the Board of Managers, OneCare Leadership, Federal and State law and regulations, and applicable accrediting and review organizations.

**VIII. References:**

Program Contracts and Requirements

**Location on Shared Drive:** S:\Groups\Managed Care Ops\OneCare Vermont\Policy and Procedures\Policies

**Management Approval:**

Director, ACO Program Operations Date

Chief Operating Officer (COO) Date

Chief Compliance Officer Date

**Board of Managers Approval:** *Requires BOM approval annually if content/substantial changes. If N/A BOM approval every two years.

Chair, OneCare VT Board of Managers Date

# ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
## BOARD OF MANAGERS MEETING
## SEPTEMBER 17, 2019

## MINUTES

A meeting of the Board of Managers of OneCare Vermont Accountable Care Organization, LLC ("OneCare") was held at Central Vermont Medical Center on September 17, 2019.

I. Call to Order

John Brumsted, M.D., called the meeting to order at 4:30 p.m. and welcomed new Board members Coleen Kohaut and Michael Costa.

II. Consent Agenda Items

The consent agenda items were approved unanimously.

A motion was made and seconded for the Board to consider a resolution invoking Participation Waiver of fraud and abuse laws for some of the second round of innovation pilots that the Board approved at the August meeting. The projects include Automated Tele-Health Intervention, Mobile Integrated Healthcare, Child Psychiatry Consultation Clinic, and Telecare Connection.

Sara Barry reminded the Board that waivers are available for arrangements that are reasonably related to ACO Activities and briefly reviewed what those are in relation to the projects. The Board considered the relationships of the projects to OneCare's ACO Activities and confirmed that Institutional Review Board review is not required for any of the projects. After discussion, the motion was approved by supermajority of the Board.

III. Policies

Tom Borys summarized the changes to the Comprehensive Payment Reform (CPR) Project Policy for 2020. Current CPR participants collaborated with OneCare management to develop the new policy. The changes maintain the core program structure and increase accountability. A motion was made, and seconded for the Board to adopt the revised CPR Policy. Dr. Haddock endorses the policy and appreciates that quality measures are aligned with Blueprint measures. After discussion the motion was approved by supermajority of the Board.

Sara Barry introduced a new Data Transparency policy. This policy describes data transparency standards in relationship to sharing of data with the ACO network for the purpose of ACO Activities. A motion was made and seconded for the Board to adopt the Data Transparency Policy. It was noted that this policy does not address research use. After discussion the motion was approved by supermajority of the Board.

Sara Barry reviewed proposed changes to the Data Use Policy. The policy language was updated to reflect current contractual requirements and best practices. Extensive definitions and clarification on the role of VITL in data use were added. A motion was made and seconded for the

Board to adopt the amended Data Use Policy. After discussion the motion was approved by supermajority of the Board.

Greg Daniels summarized revisions and updates to the Compliance Policy which is to serve as the compliance plan. Revisions included details on obligations, conflict of interest, and code of conduct. A motion was made and seconded for the Board to adopt the revised Compliance Policy. The updates made are reflective of current contracts and regulations. The Board was advised that the OneCare Compliance Committee meets quarterly and has endorsed the draft policy. After discussion the motion was approved by supermajority of the Board.

IV. Public Comment

There was no member of the public was in attendance.

V. Executive Session

VI. Voting

a. The motion to approve the Executive Session Minutes from August 20, 2019 was approved..

b. The motion to approve management to enter into a contract and to accept funding from a national foundation was approved by a supermajority of the Board.

c. The motion to approve the resolution regarding a payer program for 2020 was approved by a supermajority.

d. The motion to approve the 2020 OneCare Budget as presented was approved by a supermajority.

e. The motion to approve three additional members to the Finance committee was approved by a supermajority.

VII. Adjourn

Upon a motion made and seconded, the meeting adjourned at 6:52 p.m.

OneCare Vermont

**Attendance:**

OneCare Board Members

- ☒ Dan Bennett
- ☐ Jill Berry Bowen
- ☒ John Brumsted, MD
- ☒ Michael Costa
- ☒ Betsy Davis
- ☐ Tom Dee
- ☒ Steve Gordon
- ☒ Joe Haddock, MD
- ☐ Tomasz Jankowski
- ☒ Coleen Kohaut
- ☒ Todd Keating
- ☒ Sally Kraft, MD
- ☒ Steve LeBlanc
- ☒ Steve Leffler, MD
- ☒ Sierra Lowell
- ☒ Pamela Parsons
- ☐ Joseph Perras, MD
- ☒ Judy Peterson
- ☒ Toby Sadkin, MD
- ☒ John Sayles

OneCare Risk Strategy Committee

- ☒ Claudio Fort
- ☐ Jeffrey Haddock, MD
- ☐ Tom Manion
- ☒ Brian Nall
- ☐ Anna Noonan
- ☐ Shawn Tester

OneCare Leadership and Staff

- ☒ Vicki Loner
- ☒ Norm Ward, MD
- ☐ Joan Zipko
- ☒ Greg Daniels
- ☒ Tom Borys
- ☒ Sara Barry
- ☐ Susan Shane
- ☒ Amy Bodette
- ☒ Martita Giard
- ☒ Linda Cohen Esq.
- ☐ Spenser Weppler