OneCare Vermont Accountable Care Organization, LLC
Board of Managers Meeting Agenda
May 19, 2020
4:30 p.m. – 7:00 p.m.
Teleconference Only

Time	Agenda Item	Presenter
4:30 p.m.	Call to Order and Board Announcements	John Brumsted, MD
4:31 p.m.	Consent Agenda Items - Approval* *Vote to approve Consent Agenda items*	John Brumsted, MD
4:35 p.m.	Governance • Patient and Family Advisory Committee Nominations *Vote to approve the Resolution adding three members to the Patient and Family Advisory Committee.* • Audit Committee *Vote to approve the Resolution adopting the OneCare Audit Committee Charter and Appointing Audit Committee Chair*	John Brumsted, MD
4:45 p.m.	Network Telemedicine Support	Norman Ward, MD
4:55 p.m.	OneCare Policies* *Vote to approve Resolution adopting new and revised policies*	Sara Barry
5:05 p.m.	Public Comment Move to Executive Session	John Brumsted, MD
6:50 p.m.	Votes 1. Approve Executive Session Consent Agenda items 2. Approve Resolution to submit application to the IRS for recognition as a 501(c)(3) organization together with supporting documentation including: o Second Amended and Restated Articles of Organization, which shall also be filed with the Secretary of State and o 8th Amended and Restated Operating Agreement 3. Approve Resolution to enter into Blue Cross Primary Agreement Materially Consistent with Terms Presented 4. Approve Resolution adopting 2021 Population Health Management and Risk Sharing Policy 5. Approve Resolution adopting 2021 VBIF Policy 6. Approve Resolution adopting revised 2020 Participant Dues and Participant Fixed Payment Policies	John Brumsted, MD
7:00 p.m.	Adjourn	John Brumsted, MD

*Denotes Attachments

Attachments:

1. Consent Agenda Items
    - 1a. Draft of OneCare Board of Manager Minutes from April 15, 2020
    - 1b. Board Committee Reports
    - 1c. March Financials
    - 1d. CMO Corner
2. Governance
    - 2a. Patient and Family Advisory Committee Summary and Nominations (3)
    - 2b. PFAC Nomination Resolution
    - 2c. Audit Committee Charter
    - 2d. Audit Committee Resolution
3. Policies
    - 3a. Summary of Policy Changes
    - 3b. 04-14 – Performance Year 2021 Risk Program Participation Policy
    - 3c. 05-01 – Contract Management Policy
    - 3d. 05-12 – Participant Appeals Policy
    - 3e. Policies Resolution
4. Public Affairs Report *(FYI Only)*

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
BOARD OF MANAGERS MEETING
APRIL 15, 2020

MINUTES

A meeting of the Board of Managers of OneCare Vermont Accountable Care Organization, LLC ("OneCare") was held remote by video and phone conference on April 15, 2020.

I. Call to Order

John Brumsted, M.D., called the meeting to order at 4:35 p.m.

II. Consent Agenda Items

A motion to approve the consent agenda items was made by Betsy Davis which was seconded by John Sayles and approved by a supermajority vote.

III. Public Affairs/Regulatory/Operations Update

Green Mountain Care Board (GMCB): The GMCB approved OneCare's request for relief from the 2020 .5% Medicare Value Based Incentive Fund (VBIF) withhold from hospitals. This means that OneCare can return the amounts collected so far to the hospitals and also will not make withholds for Medicare VBIF for the rest of 2020. A motion was made by Todd Keating to approve the Resolution to return VBIF collected to date and stop withholding from hospitals which was seconded by Betsy Davis and approved by a supermajority vote.

The GMCB revised OneCare's 2020 budget orders approving most of OneCare's requests to extend deadlines for deliverables, including delaying the budget update originally due in April. This extension allows OneCare sufficient time to make the contractual and budget adjustments needed to be responsive to the pandemic. OneCare will provide the GMCB an updated budget in late May followed by a presentation on June 3. Vicki Loner, CEO, will present update the GMCB about OneCare's COVID-19 response on April 22nd.

Legislature: Vicki Loner, CEO, testified by video to the Senate Health and Welfare Committee as well as the House Health Committee on OneCare's efforts to support the health care providers on the pandemic's front line. Ms. Loner has also sent a letter to the federal delegation advocating for changes in federal CMS policies to assist providers and hold them harmless for situations out of their control.

State Administration: The State Administration and the GMCB are drafting a letter to CMMI requesting to exercise the exogenous factors clause in the All-Payer Model (APM) agreement. The letter will include recommendations that could protect providers from the financial impact of the pandemic that are unique because of their participation in the APM. OneCare management helped to draft these recommendations, including reverting to a reporting only year for quality and true fixed payments that are not subject to year-end reconciliation to fee-for-service value. A copy

of the letter will be provided to the Board once finalized and submitted to CMMI. Ms. Loner is also working with the state administration to rectify federal stimulus funding issues that are affecting Vermont providers. In its federal requests, Health and Humans Services' calculation of funding designated for the providers and provider organizations did not account for participation in advanced alternative payment models. This may have resulted in Vermont receiving less federal money than expected. The Association of Academic Medical Centers has also raised this issue and is working with Health and Human Services on an adjustment.

Network News: OneCare continues to provide updates to the network through our Network News email and has shifted to a weekly distribution to share policy changes and resources associated with the pandemic. OneCare has created a COVID-19 tool to assist providers in identifying vulnerable patients which is began rollout this week and is being well received.

Payers: OneCare management is examining and re-opening contracts with payers to address exogenous factors. Local payers have been good partners in this crisis and have been receptive to requests for telehealth flexibilities. OneCare continues to monitor actions and policies coming from of CMS/CMMI on telehealth, quality reporting, and financial policies.

IV. Policies

Sara Barry, Chief Operating Officer, provided a summary of revisions to a policy requiring approval from the Board. Policy 04-13, "Value Based Incentive Fund Policy" was revised in response to COVID-19 to adjust the language that initially referenced paying these funds out after the conclusion of the Performance Year. This provides the Board of Managers the flexibility to distribute some of the VBIF funds throughout the 2020 performance year, particularly if OneCare is able to convert to a "reporting only" year for quality. A motion was made by Dr. Steve Leffler which was seconded by Tom Dee and passed by a supermajority vote.

V. Public Comment

There were no members of public in attendance.

VI. Executive Session

VII. Voting

1. The Executive Consent Agenda was approved by a supermajority vote.
2. The Resolution Adopting the 7th Amended and Restated Operating Agreement was approved by a supermajority vote.
3. The Resolution Amending Comprehensive Payment Reform Project was approved by a supermajority vote.
4. The Resolution regarding additional Care Coordination relief measures was approved by a supermajority vote.
5. The Resolution advance paying Care Coordination and advanced PHM payments to the network was approved by a supermajority.
6. The Resolution adopting the 2021 Network Development Strategy was approved by a supermajority vote.

7. The Resolution Adopting the Compliance Work Plan was approved by a supermajority vote.

VIII. Adjourn

Upon a motion made and seconded, the meeting adjourned at 6:08 p.m.

Attendance:

OneCare Board Members

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

OneCare Risk Strategy Committee

☐ Jeffrey Haddock, MD	☐ Anna Noonan
☐ Tom Manion	☒ Shawn Tester
☐ Brian Nall	☐ Joe Woodin

OneCare Leadership and Staff

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

OneCare Board of Manager Committee Report-Outs May 2020

Executive Committee

At its May 5th meeting the committee continued to discuss the impact of the COVID-19 pandemic on existing payer contracts, including clauses to address the pandemic. The committee was provided a preview of the 2021 Network Support strategy including new policies regarding Population Health Management and Value Based Incentive Fund. The committee was provided an update on the 501(c)(3) application submission to the IRS. The Audit Committee Charter and Nomination for the Chair of the committee was discussed and both were endorsed and referred to the full Board. Patient and Family Advisory Committee Nominees were also shared and discussed and also endorsed and referred to the full Board. Lastly, the committee was provided a financial update including operational savings and federal stimulus funding.

Audit Committee

At its first meeting on May 6th, the committee reviewed and approved the Audit Committee Charter and approved a motion for Audit Committee Chair to send Dan Bennet's name to the Executive Committee serving as the Nominating Committee for consideration and referral to the full Board. The committee also reviewed and approved the Compliance Committee Charter. The committee discussed the Compliance Plan and reviewed and approved the plan as approved by the Board of Managers. The committee was provided a presentation for the 2019 Audit Plan by PricewaterhouseCoopers.

Finance Committee

At its May 13th meeting, the agenda consisted of the report out of the March 2020 Financial Statements. There was a discussion around the 2021 Policies around Population Health Management Payment, VBIF, Hospital Dues Policy, Fixed Payment Policy and Risk Participation Policy. The members had a discussion around Reinsurance. The committee concluded the meeting with future topics for discussion around the Hospital Budget Data and 2020 MRL Addendums.

Population Health Strategy Committee

The May 5th committee meeting began with a discussion on the methodology around the 2021 Population Health Management with a vote from members. There were four Board Resolutions shared. Tyler presented the new COVID-19 Engagement Program. Dr. Ward provided an update on the Telehealth Billing specifics. There was updates around the VBIF 2021 Methodology plans with a vote. The next scheduled meeting is June 1st.

Clinical & Quality Advisory Committee

The committee is scheduled to meet next on June 11th. Agenda is TBD.

Patient & Family Advisory Committee

At its May 14th meeting, the members heard a presentation from Jenn Gordon on the OneCare Care Coordination work. This committee now meets monthly and will meet again on June 9th.

Pediatric Subcommittee

This committee meets next on May 21st. The drafted agenda consists of a presentation around the school based vaccine administration program by Breena Holmes and Chris Finley with VDH. Ginger Irish will provide a presentation on the functionality and familiarize the members with the Vermont Health Learn Platform. There will be an update on the Pediatric Patient Attribution numbers and Care Navigator. Dr. Ward plans to provide an Algorex Usage update and OneCare updates.

OneCare Vermont

Statement of Financial Position

For the Periods Ended

	3/31/2020	2/29/2020	Variance
ASSETS			
Current assets:			
Unrestricted Cash	6,120,874	6,628,797	(507,923)
GCMB Reserve Funding	4,000,000	4,000,000	-
CMS Reserve-US Bank	5,989,783	5,987,852	1,930
VBIF-2017	111,041	111,041	0
VBIF-2018	7,310,114	7,310,114	-
VBIF-2020	1,629,240	1,086,160	543,080
Advance Funding-Medicaid	13,688,724	13,859,435	(170,711)
Undistributed Medicare - 2019	6,442,801	6,442,801	-
Total Cash	45,292,577	45,426,201	(133,624)
Network Recievable	1,995,631	2,325,391	(329,760)
Network Recievable-Settlement	(46,211)	(46,211)	-
Other Receivable	3,457,600	3,378,602	78,998
Other Receivable-Settlement	(0)	(0)	-
Prepaid Expense	120,749	934,150	(813,401)
TOTAL ASSETS	**50,820,346**	**52,018,133**	**(1,197,787)**
LIABILITIES AND NET ASSETS			
Current liabilities:			
Accrued Expenses	1,830,014.20	1,537,178.13	292,836
Accrued Expenses -Settlement	8,323	8,323	-
Network Payable	16,275,467	15,883,532	391,935
Network Payable-settlement	-	-	-
Notes Payable	4,124,849	4,124,849	-
CTO Liability	429,711	406,885	22,826
Payroll accrual	120,254	93,003	27,251
Deferred Income	18,324,969	19,348,046	(1,023,077)
Estimated third-party payer settlements	-	-	-
Due to Related Parties - UVMMC	2,930,416	3,457,720	(527,305)
Due to Related Parties - DHH	(1)	(1)	-
Total Liabilities	**44,044,001**	**44,859,535**	**(815,534)**
Net assets:			
Unrestricted - UVMMC	2,916,713	2,916,711	2
Unrestricted - DHH	2,916,713	2,916,713	-
Current Year Profit to Date	942,920	1,325,173	(382,253)
Total net assets	**6,776,345**	**7,158,596**	**(382,251)**
TOTAL LIABILITIES AND NET ASSETS	**50,820,346**	**52,018,131**	**(1,197,784)**

OneCare Vermont

Surplus & Loss Statement: YTD March 2020

	Annual Budget	March Actual	CM Budget	Month Variance	YTD Actual	YTD Budget	YTD Variance
Fixed Prospective Payment Funding							
Hospital FPP - Medicare	$ 219,868,930	18,448,383	18,322,411	125,972	$ 55,345,148	$ 54,967,233	377,915
Hospital FPP - Medicaid	$ 164,327,750	13,628,427	13,693,979	(65,552)	$ 41,744,713	$ 41,081,938	662,776
CPR FPP- Medicare	$ 2,126,846	177,237	177,237	0	$ 531,712	$ 531,712	0
CPR FPP - Medicaid	$ 2,496,946	220,751	208,079	12,673	$ 671,752	$ 624,237	47,516
Program Support - Medicaid CCC/DULCE	$ 4,300,000	373,416	358,333	15,083	$ 1,144,487	$ 1,075,000	69,487
Total Fixed Prospective Payments Funding	$ 393,120,472	32,848,215	32,760,039	88,175	$ 99,437,812	$ 98,280,118	$ 1,157,694
Payor Contracts: Provider Support Funding							
PHM Program Support							
Program Support - Medicaid Trad $3.25	$ 3,000,410	259,002	250,034	8,968	$ 788,749	$ 750,102	38,647
Program Support - Medicaid Expanded $1.75	$ 398,988	34,946	33,249	1,697	$ 107,741	$ 99,747	7,994
Program Support - Blue Cross QHP $3.25	$ 726,644	65,975	60,554	5,421	$ 197,925	$ 181,661	16,264
Program Support - Blue Cross Primary $3.25	$ 3,122,637	-	260,220	(260,220)	$ -	$ 780,659	(780,659)
Program Support - MVP 3.25	$ 523,176	52,000	43,598	8,402	$ 156,000	$ 130,794	25,206
Program Support - MVP CCC	$ 73,798	6,150	6,150	0	$ 18,450	$ 18,450	0
Program Support - Addtl DSR Funding	$ 3,900,000	-	325,000	(325,000)	$ -	$ 975,000	(975,000)
Total Payer Contract Provider Support	$ 11,745,653	418,073	978,804	(560,731)	$ 1,268,865	$ 2,936,413	$ (1,667,549)
Payer Contracts: Operations Support Funding							
Operations Funding - Medicaid Trad $3.25	$ 3,000,410	259,002	250,034	8,968	$ 788,749	$ 750,102	38,647
Operations Funding - Medicaid Exp $5.00	$ 740,978	64,899	61,748	3,151	$ 200,090	$ 185,244	14,845
Program Support - Medicaid HIT	$ 3,500,000	233,333	291,667	(58,334)	$ 699,999	$ 875,000	(175,001)
Total Payer Contract Operations Support	$ 7,241,387	557,235	603,449	(46,214)	$ 1,688,838	$ 1,810,347	$ (121,509)
Total Payor Contracts Funding	$ 18,987,040	975,308	1,582,253	(606,946)	$ 2,957,702	$ 4,746,760	$ (1,789,058)
Other Funding							
Medicare Shared Savings/Blueprint	$ 8,401,660	700,138	700,138	(0)	$ 2,100,414	$ 2,100,415	(1)
Robert Wood Johnson Grant	$ 75,000	-	6,250	(6,250)	$ -	$ 18,750	(18,750)
VBIF Reinvestment	$ 33,000	-	2,750	(2,750)	$ -	$ 8,250	(8,250)
Miscellaneous Revenue	$ 240,753	19,930	20,063	(132)	$ 83,804	$ 60,188	23,615
Total Other Funding	$ 8,750,413	720,068	$ 729,201	(9,133)	$ 2,184,218	$ 2,187,603	$ (3,386)
Participation Fees	$ 24,968,471	1,645,990	2,080,706	(434,716)	$ 5,922,178	$ 6,242,118	(319,939)
Total Funding	**$ 445,826,396**	**36,189,581**	**$ 37,152,200**	**(962,619)**	**$ 110,501,910**	**$ 111,456,599**	**$ (954,689)**
Hospital FPP - Medicare	$ 219,868,930	18,448,383	18,322,411	(125,972)	51,142,169	$ 54,967,233	3,825,064
Hospital FPP - Medicaid	$ 164,327,750	13,628,427	13,693,979	65,552	45,947,692	$ 41,081,938	(4,865,755)
Total Hospital FPP	$ 384,196,680	32,076,810	$ 32,016,390	(60,420)	$ 97,089,861	$ 96,049,170	$ (1,040,691)
CPR FPP- Medicare	$ 2,126,846	177,237	177,237	(0)	$ 531,712	$ 531,712	(0)
CPR FPP - Medicaid	$ 2,496,946	220,751	208,079	(12,673)	$ 671,752	$ 624,237	(47,516)
Total CPR FPP	$ 4,623,792	397,989	$ 385,316	(12,673)	$ 1,203,464	$ 1,155,948	$ (47,516)
Populations Health Mgmt Payment	$ 8,682,107	299,638	723,509	423,870	1,262,080	$ 2,170,527	908,447
Complex Care Coordination Program	$ 8,205,184	777,974	683,765	(94,209)	2,145,505	$ 2,051,296	(94,209)
PCP Engagement Incentive Pmt - Medicaid Expanded	$ 398,988	33,249	33,249	(0)	99,747	$ 99,747	0
PCP Engagement Incentive Pmt - BCBSVT Primary	$ 215,180	-	17,932	17,932	-	$ 53,795	53,795
Value-Based Incentive Fund	$ 6,737,657	543,080	561,471	18,391	1,629,240	$ 1,684,414	55,174
Primary Prevention Programs	$ 540,000	34,895	45,000	10,105	80,324	$ 135,000	54,676
CPR Program Expense - OCV Funded	$ 1,178,196	114,563	98,183	(16,380)	276,086	$ 294,549	18,463
DULCE	$ 300,000	-	25,000	25,000	32,175	$ 75,000	42,825
Longitudinal Care	$ 500,000	-	41,667	41,667	-	$ 125,000	125,000
Network Reform Projects	$ 2,086,321	45,315	173,860	128,545	190,185	$ 521,580	331,396
PCHP Program Initiative	$ 14,000	-	1,167	1,167	-	$ 3,500	3,500
VBIF Quality Initiatives	$ 33,000	-	2,750	2,750	-	$ 8,250	8,250
PCMH Legacy Payments - Blueprint	$ 1,993,092	166,091	166,091	-	498,273	$ 498,273	-
CHT Block Payment - Blueprint	$ 2,440,322	203,360	203,360	(0)	610,081	$ 610,081	(0)
SASH- Blueprint	$ 3,968,246	330,687	330,687	(0)	992,061	$ 992,061	(0)
VBIF Reinvestment	$ -	-	-	-	-	$ -	-
PHM Expense	$ 37,292,292	2,548,853	$ 3,107,691	$ 558,838	$ 7,815,757	$ 9,323,073	$ 1,507,316
Salaries and Fringe	$ 11,801,439	658,108	983,453	325,345	1,962,367	$ 2,950,360	987,993
Purchased Services	$ 1,213,263	176,134	101,105	(75,029)	125,789	$ 303,316	177,526
Contract & Maintenance	$ 155,250	6,824	12,938	6,113	18,308	$ 38,813	20,505
Lease & Rental	$ 483,015	40,032	40,251	220	102,376	$ 120,754	18,378
Utilities	$ 39,724	3,205	3,310	105	9,718	$ 9,931	213
Other Expenses	6,020,941	663,879	501,745	(162,134)	1,231,350	$ 1,505,235	273,885
Total Operating Expenses	$ 19,713,632	1,548,182	$ 1,642,803	$ 94,621	$ 3,449,908	$ 4,928,408	$ 1,478,500
Total Expenses	**$ 445,826,396**	**36,571,833**	**$ 37,152,200**	**580,366**	**$ 109,558,990**	**$ 111,456,599**	**$ 1,897,609**
Net Income (Loss)	**$ -**	**(382,253)**	**$ -**	**(382,253)**	**$ 942,920**	**$ -**	**$ 942,920**

OneCare Vermont Board of Managers

May 19, 2020

CMO Corner

1. **Telehealth** – OneCare Vermont continues to advocate with other statewide entities to optimize the use of telemedicine (video visits), telephone-only, expanded telehealth service benefits, and innovative models for the future. Judy Peterson and Dr. Sally Kraft met with OneCare leadership on April 27 to discuss overall telehealth strategy. The Population Health Strategy Committee at its meeting on May 5 was updated as to plans for a network wide survey of barriers to and needs for telehealth services such as access, training, equipment, and workforce. Dr. Ward presented on April 23 to the New England Telehealth Resource Center-Vermont Program for Quality Health Care Telehealth Office Hours webinar on "Telehealth in the Post-COVID World." OneCare continues to interact with Bi-State Primary Care (FQHC advocacy), Healthcentrics Advisors (CMS Quality Improvement Organization for Vermont), the National Association of Accountable Care Organizations, the Vermont Medical Society, VPQHC, NETRC, DVHA, Blue Cross of Vermont and the UVM Health Network on telehealth issue information sharing. The April 30 Interim Final Rule released by CMS provided considerable help with improved benefits and reimbursement for telehealth services but leaves many issues unresolved when the Public Health Emergency (PHE) is declared ended.

2. **Vermont Medicaid Next Generation Prior Authorization Waiver** – OneCare staff met with Department of Health Access representatives on May 12 to discuss DVHA requested modifications to the provisions of this waiver in place since the 2017 inaugural year of this program. Issues under discussion include prior authorization of physician administered medications (J code drugs), out of network services, prevention of imminent harm, and review of use of "miscellaneous service" codes. The OneCare Network will be appraised in a timely fashion as to any significant changes that may result from these discussions.

3. **Health Service Area Performance Consultations** – OneCare Vermont management, analytic, and financial teams are preparing a process to meet with leadership in each health service area to provide a more in depth analysis of regional utilization, quality, and cost parameters. These insights can serve in support of care delivery modifications at the local level that would have anticipated beneficial effects on clinical quality and resource use. Meetings are anticipated to begin in July.

4. **COVID-19 Care Coordination Prioritization Application** – Dr. Shane, Jodi Frei, Tyler Gauthier, and Katie Muir presented May 5 at the Healthcentrics Advisors ECHO- New England Webinar on the use of this home grown data tool derived from OneCare Vermont claims data to a large New England audience. The audience was impressed with the sophistication of the tool and its function as a way to trigger outreach for those at greatest risk of adverse outcomes from COVID. The tool has been made available to the entire OneCare Vermont network.

OneCare Vermont

Audit Committee Charter

I. Charge:

The Audit Committee ("Committee") is a standing committee of the OneCare Vermont Accountable Care Organization, LLC ("OneCare") Board of Managers ("Board"). The Committee is charged with making recommendations to the Board regarding oversight of OneCare's risk management, financial reporting, and audit functions.

II. Committee Leadership and Member Appointment:

The Committee will be chaired by a Member of the Board of Managers. The Chair will preside over each meeting. In the absence of the Chair, a designated member of the Committee will act as the Chair. The Board will appoint members to the Committee by supermajority vote based on nominations by the Board's Executive Committee.

The Chair will work with the Finance leader, or designee, and Chief Compliance and Privacy Officer ("CCPO") to receive and provide feedback and guidance in preparation for and in between meetings of Committee.

III. Committee Composition:

The Committee shall be comprised of no fewer than three (3) and no more than five (5) members, each of whom shall be a Member of the Board. The Board's Chair shall be an *ex officio* voting member of the Committee. Each member of the Committee shall have one (1) vote.

The Chief Executive Officer ("CEO") and Legal Counsel may be designated as ad-hoc participants of the committee at its discretion.

IV. Accountabilities:

The Committee reports to the Board. The Committee's primary role is to provide input and support to the Board and CEO regarding OneCare's operations in the areas set forth in the General Statement of Purpose.

V. OneCare Staff Support:

The Committee will be assisted by OneCare's Finance leader and CCPO. The Audit Committee may request such other assistance from other OneCare staff as reasonably necessary to carry out its charge.

VI. Scope:

The Committee's principle responsibility is to oversee OneCare's control (financial and regulatory) environment, and to provide independent advice to the Board regarding the adequacy and effectiveness of management's control practices, including recommendations for improvements to current practices. This will require the following activities:

1. Reviewing and assessing annual financial statements with management and outside auditors before they are released to the public or filed with state or federal regulators;
2. Recommending approval of any proposed changes in accounting principles and practices, and the application of such changes in all financial reporting, by the Board;
3. Recommending approval of the selection of external auditor(s) by the Board;
4. Reviewing and assessing OneCare's systems of internal control for detecting errors, fraud, tax-code violations, and/or noncompliance with OneCare's Code of Conduct, Compliance, or Conflict of Interest Policies;
5. Reviewing the results of audits prepared by internal and/or external auditors;
6. Reviewing the performance of external and internal auditors;
7. Meeting with external and/or internal auditors to discuss their judgement of accounting principles and financial practices used or proposed by OneCare;
8. Reviewing and discussing any recommendations to the Board relating to any significant findings of internal or external auditors;
9. Establishing and monitoring procedures for receipt, retention, and handling of complaints regarding OneCare's accounting and/or internal audit controls, including procedures for confidential submission of complaints by any member(s) of OneCare's Workforce;
10. Reviewing and updating the Code of Conduct and Compliance and Conflict of Interest Policies, including providing education and training to OneCare's Members, Board, Workforce, and management to assure adherence;
11. Reviewing and analyzing significant conflicts of interest in order to make recommendations to the Board;
12. Addressing any inquiries or complaints regarding application, compliance, or noncompliance with the Code of Conduct, Compliance or Conflict of Interest Policies, and/or generally accepted ethical standards;
13. Reviewing OneCare's internal audit plan; and
14. Conducting and/or overseeing investigations into any matter within the Committee's scope of responsibility. In consultation with the Board, the

Committee may also take over and maintain control any existing investigation within its scope (e.g. investigations) by the CCPO or Compliance Committee). The Committee shall have the power to retain independent legal counsel of its choosing, as well as any other professionals it deems necessary, to assist in the conduct of any such investigation(s).

VII. Frequency of Meetings:

The Committee shall meet at least four (4) times per calendar year, but will have the option to meet more frequently as deemed necessary, or when called by, the Chair or any two members of the Committee. Where permitted by OneCare's Board, the Committee may act by a majority vote of members, which shall constitute a quorum for purposes of a Meeting.

Generally, the Committee shall meet in person or by conference telephone, however asynchronous communication[1] may be utilized at the discretion of the Chair or CEO when time-sensitive matters arise, as permitted by law. When calling a Meeting, the Chair or CEO shall designate whether it will be conducted asynchronously, rather than in-person. A majority of Committee members present, or participating in asynchronous communication, shall constitute a quorum.

The Committee shall record Minutes at each Meeting and shall preserve records and documents related to Meeting(s) conducted by asynchronous communications.

Except when called on an emergency basis, notice of Committee Meetings and related materials will be distributed to Committee members at least three (3) business days prior to the date of the Meeting.

[1] E.g. email, text, or other electronically-recorded communication.

OneCare Vermont Accountable Care Organization
Board of Managers Resolution
Audit Committee Charter and Chair

May 19, 2020

BE IT RESOLVED by the Board of Managers (the "Board") of OneCare Vermont Accountable Care Organization, LLC ("OneCare") as follows:

The Board, having reviewed and discussed:

a. the proposed Audit Committee Charter, hereby approves the Charter; and

b. the recommendations of the Audit and Nominating Committee, the qualifications of the candidate, hereby approve the Audit Committee Charter and appoints Dan Bennett, as Chair of the Audit Committee.

Board of Managers
Policy Summary
May 2020

OneCare leadership has reviewed and recommends the following policy changes for approval by the Board of Managers.

- **04-14 Risk Program Participation**
  - **Description:** Provides direction on ACO Network participation in risk-based contracts and circumstances under which exceptions for broad risk participation may be granted.
  - **Key Changes:** Minor updates to this policy include clarifications on timing for participation in multiple risk programs and addition of an exogenous factors clause as a possible reason an ACO Participant is unable to participate in additional risk programs.

- **05-01 Contract Management** *(New Policy)*
  - **Description:** Establishes a uniform policy for the drafting, review, approval, management and retention of all OneCare contracts.
  - **Key Features:** New policy that describes contracting accountabilities of the Director of ACO Contracting or designee, legal counsel, and Responsible Officers. Establishes a Contract Summary form and Legal Review form to be completed in the contracting process and provides guidelines for contract provisions.

- **05-02 Participant Appeals** *(formerly 06-12)*
  - **Description:** Outlines the guidelines for Participants and Preferred Providers to appeal a determination, decision, or action made or taken by OneCare in relation to the Participant's or Preferred Provider's participation in any ACO Payer Program.
  - **Key Changes:** The changes in this policy reflect recent updates to leadership responsibilities. Ownership of this policy has transitioned from the Director of ACO Program Operations to the Director of ACO Contracting. Responsibility has shifted from the CEO to the COO for assigning a substitute for the Director of Contracting to address Level 1 Appeals, as well as to identify other officers and/or directors to participate in a Level 2 Voluntary Appeals, if necessary. Policy content was reorganized for added clarity.

Policy Number & Title:	04-14 Risk Program Participation
Responsible Department/s:	Finance
Author:	Tom Borys, Sr. Director, ACO Finance and Payment Reform
Date Implemented:	April 16, 2019
Date Reviewed/Revised:	May 1, 2020
Next Review Date:	March 1, 2021

I. Purpose: To have a policy to guide the exercise of discretion as to whether a new (e.g. first year) or current ACO Participant may be permitted to not participate in a Risk program.

II. Policy Statement: It is the general policy of OneCare that new risk ACO Participants be offered to participate in all risk ACO Programs but in year one may choose to only start in the Vermont Medicaid Next Generation Program. Existing Participants are encouraged to move into additional Risk programs in subsequent years so long as the ACO Participant is a Participating Provider with the payer offering the risk ACO Program. If they are unable to participate in additional Risk programs, due to one of the circumstances listed below, Management will work with the participant to identify other "upside" only ACO programs or pilots that are available to the participant and community and would count towards scale targets.

III. Definitions:

ACO Program: refers to a program between ACO and a Payer for population health management through an alternative payment arrangement.

Participant or Participating Provider: refers to a health care provider that has entered into a Participant/Affiliate Agreement with OneCare.

Risk: is more particularly defined by each ACO Program, but generally means the portion of performance year spending that is either greater than or less than expected spending. In the case where the performance year spending is greater than expected, a portion, as defined by each ACO Program, must be returned to the payer.

IV. Circumstances:

ACO Participant demonstrates to the reasonable satisfaction of ACO Management any of the following circumstances.

1. ACO Participant is already contracted as an Attributing Participant in another Medicare Program or Medicare ACO outside of Vermont (Medicare Exclusivity Rule).

2. ACO Participant is not an Eligible provider in the Payer Program.

3. ACO Participant is in a material legal dispute with a Payer.

4. ACO Participant who has participated in a Risk ACO Program is unable to participate in additional risk ACO Programs because additional financial risk is deemed untenable by the organization as defined by the organization's Governing Board.

5. ACO Participant who has participated in a Risk Program is unable to participate in additional ACO risk Programs because the operational demands would materially negatively impact their

organization's operations or the organization does not have the resource capacity to fully participate in the clinical and quality programs of the ACO.

6. ACO Participant who has participated in a Risk Program is unable to participate in additional ACO Risk Programs because of significant senior leadership changes or transitions (recent past or future) that has the potential to impact growth, workforce, administration and or operations.

7. Other exogenous factors such as a natural disaster, epidemiological event, legislative change, or other similarly unforeseen circumstance that inhibits the ACO Participant's ability to fully participate in the clinical and quality programs of the ACO.

If a participant is requesting to defer participation in additional risk programs for any circumstances not listed above, the CEO of OneCare will review the request, and bring to Board of Managers as needed.

Related Polices/Procedures: N/A

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

Management Approval:

Sr. Director, ACO Finance and Payment Reform	Date
Chief Operating Officer	Date

Board of Managers Approval:

Chair, OneCare Board of Managers	Date

Policy Number & Title:	05-01 Contract Management
Responsible Department(s):	Contracting
Author(s):	Sara Barry, Chief Operating Officer Linda Cohen, ACO Legal Counsel
Date Implemented:	July 1, 2020
Date Revised:	
Next Review Date:	May 1, 2021

I. Purpose: The purpose of this document is to establish a uniform policy for drafting, review, approval, execution, management, and retention of contracts involving OneCare Vermont Accountable Care Organization, LLC ("OneCare") to ensure that its contractual arrangements are lawful, consistent with business interests, and comply with policies and procedures.

II. Policy Statement and Scope: All Contracts involving OneCare as a party shall be drafted, reviewed, approved, executed, managed, and retained in accordance with this Policy. OneCare will not enter non-written, verbal contracts and shall not attempt to bind itself outside of a written agreement.

III. Definitions:

Any terms used within this Policy that are defined in the *Glossary of Terms for Policies and Procedures* shall have the meaning assigned in that glossary.

"ACO Legal Counsel" is the designated legal representative for OneCare, with the authority and responsibility (through employment or contractually) to review and approve the legal terms and conditions for a Contract. ACO Legal Counsel shall be engaged at appropriate times throughout the contracting process and must provide Legal Review before any Contract is signed by a Responsible Signatory.

"Business Lead" is a representative of the business unit or department requesting the Contract. The Business Lead shall: (i) provide the business terms, goals and information reasonably necessary for the Contract to reflect the arrangement desired; (ii) liaise with the Contracting Department to secure information, answer questions, provide support for the contracting process; (iii) assist to implement and monitor the Contract and (iv) provide support for renewal and termination decisions.

"Business Review" is the process by which every Contract is reviewed by the Business Lead, other identified subject matter experts, and the Contracting Department to assure that the terms of the Contract are consistent with the business goals and objectives of OneCare. The Business Review shall be consistent with other applicable policies of OneCare.

"Contract" is any form of promise or agreement intended to bind OneCare or that may potentially be enforced against OneCare by another party, regardless of its format. This includes, but is not limited to, memorandum of understanding, letter of intent, lease, letter agreement, settlement agreement and

amendments to existing agreements. All Contracts must be in writing and signed by a Responsible Signatory in order to be recognized as enforceable by OneCare.

"Contract Liaison" is a representative of the OneCare Contracting Department responsible for drafting, reviewing, and managing contracting processes as set forth in this Policy. In no circumstance will the Contract Liaison have the authority to make legal determinations or decisions.

"Legal Review" is the process by which Contracts, other than those excepted from this Policy, are reviewed by ACO Legal Counsel, or his/her designee, to assure that the terms of the Contract are consistent with the legal, contractual and regulatory obligations of OneCare and OneCare's business objectives and strategy.

"Responsible Signatory" is a representative of OneCare with the authority to contractually bind the organization up to the representative's authorization level as stated in other OneCare Policies and governance documents. The CEO, COO, and CFO are Responsible Signatories.

IV. Application: This Policy applies to all Contracts entered into by OneCare. This includes Contracts that are drafted by OneCare independently, jointly drafted Contracts, and Contracts proposed by other parties.

V. Policy:

A. Contract Approvals

1. Required Reviews and Approvals. Unless an exception is established, no Contract shall be executed unless: (i) the Contract has been approved by the Responsible Signatory following a favorable Business Review; (ii) the Contracting Department has reviewed for clarity, required provisions and prohibited provisions; (iii) a Legal Review is favorably completed; and (iv) any required Board approval has been obtained.

2. Authority to Execute Contracts. Contracts may be executed only by a Responsible Signatory, except that no Responsible Signatory may sign a Contract that binds OneCare to an amount in excess of the Signatory's authorization level under other applicable OneCare policies. (See, e.g. Policy FINC3, Levels of Authorization)

3. Board Approvals. OneCare's Board must approve execution of any Contract by which OneCare enters into a material arrangement which includes: (i) a value based payment program; (ii) any arrangement that uses a Participation Waiver of fraud and abuse laws; or (iii) arrangements where OneCare engages in a transactions for which Board approval is required by law, the Operating Agreement as amended from time to time or recommended by ACO Legal Counsel.

4. Unauthorized Contracts. No Contract will be recognized by OneCare as binding unless it has been reviewed and executed in compliance with this Policy. OneCare staff or representatives who attempt to or who do enter into a Contract without authority, or compliance with this Policy may be subject to disciplinary action OneCare will vigorously defend against any efforts to hold it responsible for any unauthorized contract.

5. Exceptions. Any exceptions to this Policy must be requested in writing, with support for a good faith, legally compliant reason to make an exception, and each exception must be approved by the COO or his/her designee after consultation to ensure OneCare's obligations will be met.

B. Contract Management

1. Contract Initiation and Drafting

The Contracting Department , shall have primary responsibility for the intake, development, review (including Business and Legal Review) execution, entry into contracts management database, implementation, and management of a Contract as those supporting tasks are allocated by OneCare procedures.

a) Preparation of Contract. The Contracting Department shall lead the preparation, negotiation, and development of the form and terms of the Contract, using to the extent practical, Contract templates and standard provisions. The Contracting Department shall coordinate, as appropriate, with other departments effected by the Contract.

b) Contract Templates, Standard Provisions. ACO Legal Counsel, in cooperation with the Contracting Department may, when appropriate, make available standard contract templates, forms, or provisions for use in all Contracts or particular types of Contracts (e.g. personal services contract template, or no agreements to pay for referrals*).* The Contracting Department will use these templates in the contract management process. Regardless of template used, all Contracts must comply with all other aspects of this Policy.

2. Contract Review

a) Business Review. Every Contract shall be subject to a Business Review to assure that the terms of the Contract are consistent with the business goals and objectives of OneCare. To the extent that the Business Review raises business or operational issues, the Contracting Department shall follow up with the appropriate leaders to resolve those issues.

b) Legal Review. Except for the Contracts specified below, every proposed Contract shall be presented to ACO Legal Counsel with a Business Review for legal review and approval. Legal Review includes evaluation of potential liabilities and risks; compliance with contractual, regulatory and legal obligations; and strategic alignment of terms with OneCare's business goals and objectives. The following Contracts shall not require legal review:

   i. Contracts in the ordinary course of business under a form of agreement template or exclusively using standard terms and conditions that have been approved in advance by ACO Legal Counsel.

c) Business Agreements. If a Contract will require OneCare to disclose individually-identifiable health information to a third party, a "Business Associate Agreement", in a

form approved by the Chief Compliance and Privacy Officer and ACO Legal Counsel, must be executed between OneCare and the third party in advance of any sharing of the data and/or protected health information.

d) Data Use Agreements. If a Contract will require OneCare to disclose data that is owned by a party other than OneCare and is subject to a Data Use Agreement, including but not limited to claims data, information derived from claims feeds, or other similarly protected data (collectively "protected data"), a Data Use Agreement must be executed between OneCare and the third party, subject to approval by the owner of the protected data.

e) Excluded Persons. OneCare will not knowingly contract with or retain on its behalf any person or entity that has been convicted of a criminal offense related to health care or which has been listed by a federal agency as ineligible for federal program participation. The Contracting Department will be responsible for performing and documenting federal exclusion and required background checks.

3. Contract Execution

a) Presentation to Responsible Signatory. Once the Business Review and Legal Review (or an exception demonstrated) are completed, and the Contract is approved for execution, the Contracting Department shall provide the Responsible Signatory with the salient information reasonably required to enter the Contract on behalf of OneCare. The information should include: documentation of compliance with this Policy and associated procedures; a summary of any significant concerns or issues raised in the contracting and review process; identified risks and mitigation strategies; and OneCare's goals and objectives for the Contract and the final Contract. The format of presenting this information shall be established by procedure.

b) Signature. The Contracting Department shall assure the Contract is duly executed by all parties.

4. Contract Management

a) Contracts Management Database. The Contracting Department shall establish and maintain a searchable computer database for Contracts subject to this Policy. Procedures governing authorization to access the database will be developed and maintained in support of this Policy.

b) Retention of Contracts. Fully executed copies of every Contract and supporting documentation shall be maintained by the Contracting Department in a contract management system. The Contract shall be maintained in accordance with OneCare's *Maintenance of Records Policy.* Authorization for the contract management system shall be controlled by relevant procedures.

c) Payment and Accounting. All Contracts involving the exchange of funds or goods shall be shared by the Contracting Department with the finance department upon Contract execution.

5. **Monitoring Contract Performance:**

a) Implementation and Deliverables. The Contracting Department will be responsible for tracking the Contract and its performance to facilitate: (i) Contract implementation; (ii) awareness of and meeting Contract terms and conditions, such as deliverables and deadlines; (iii) addressing questions or issues about the Contract; (iv) incorporating changes or modifications; and (v) OneCare's receipt of obligations owed to it under the Contract.

b) Contract Termination or Extension. The Contracting Department will advise Business Leads of the impending termination of a Contract with enough notice for Business consideration of the whether to extend the Contract. If extending, this Policy will be applicable to the extension documents.

VI. Review Process

This Policy will be monitored regularly for any changes required by payer program updates, changes to network contracting, changes in federal or state laws or regulation or other factors that may impact this Policy.

VII. References

1. Glossary of Terms for Policies and Procedures
   a. Location: S:\Groups\Managed Care Ops\OneCare Vermont\Policy and Procedures\Templates & Info

Related Policies/Procedures/Forms:

1. OneCare Maintenance of Records policy
2. Contract Summary Form
3. Legal Review Form
4. Guidelines for Contract Provisions
5. Checklist for Contract Execution Form
6. Policy FINC3 "Levels of Authorization"

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

Management Approval:

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Director, ACO Contracting Date

_____

Chief Operating Officer Date

_____

ACO Legal Counsel Date

Board of Manager Approval: **Requires BOM approval annually.*

_____

Chair of the Board of Managers Date

Policy Number & Title:	05-02 Participant & Preferred Provider Appeals Policy
Responsible Department(s):	ACO Contracting
Author(s):	Martita Giard, Director, ACO Contracting
Date Implemented:	July 19, 2016
Date Reviewed/Revised:	April 1, 2020
Next Review Date:	March 1, 2021

I. Purpose: To outline the guidelines for Participants and Preferred Providers to appeal a determination, decision, or action made or taken by OneCare Vermont (ACO) in relation to the Participant's or Preferred Provider's participation in any ACO Payer Program(s).

II. Scope: This policy applies to Participants and Preferred Providers contracted with OneCare Vermont and performing as a Participant or Preferred Provider in the ACO network.

III. Applicability:

Determinations, decisions, or actions that may be appealed under this Policy include, but are not limited to::

- Calculation of shared savings or loss (risk), distributions, or assessments;
- Calculation of capitated or other alternative fee-for-service program payments;
- Discipline, sanction, or termination of a Participant, Preferred Provider, or Provider from an ACO Program;
- Denial of a request to participate in an ACO Payer Program; and
- Sharing or distribution of a Participant's or Preferred Provider's performance data.

IV. Definitions:

Participant means an individual or group of Providers that is: (1) identified by a TIN; (2) included on any list of Participants submitted by ACO to Payers; (3) qualifies to attribute lives in ACO Payer Programs; and (4) that has entered into a Risk Bearing Participant & Preferred Provider Agreement with ACO. Participant may be more particularly defined in each ACO Payer Program.

Preferred Provider means an individual or an entity that: (1) is identified by a TIN; (2) if required by ACO Payer(s), is included on the list of Preferred Providers submitted by ACO to Payer(s); (3) does not qualify to attribute lives in ACO Programs; and (4) has entered into a Risk Bearing Participant and Preferred Provider Agreement with ACO. Preferred Provider may be more particularly defined in each ACO Payer Program.

V. Description/Policy:

Before filing an appeal, a Participant or Preferred Provider is encouraged to contact the ACO to determine whether the dispute can be resolved informally.

A Participant or Preferred Provider may not request an appeal for any issue the ACO is prohibited from appealing to the Payer under the relevant ACO Program.

The Appeals process begins with a Level 1 Appeal. If the Participant or Preferred Provider is not satisfied with the ACO's Level 1 decision, the Participant or Preferred Provider may request reconsideration through a Level 2 Voluntary Appeal.

A. Level 1 Appeal:

A Participant or Preferred Provider may submit a Level 1 Appeal in writing within ninety calendar (90) days of the date it receives notice of the issue in dispute.

A Level 1 Appeal must include the following information:

- The full legal business name and Tax Identification Number ("TIN") of the Participant or Preferred Provider contracted with the ACO to participate in an ACO Payer Program;
- The relevant ACO Payer Program;
- The name(s) and National Provider Identifier(s) ("NPI") of any individual Provider(s) who may be relevant to the issue(s) being appealed;
- Statement of the determination, decision or action being appealed with sufficient detail to inform the ACO of any relevant issues; and
- Any relevant supporting information and documentation.

The ACO will provide written acknowledgement to the Participant or Preferred Provider of its receipt of the appeal, and will make any initial requests for additional information or documentation, within fifteen (15) business days of receiving said appeal. The ACO may make additional requests for information or documents outside of this timeframe if necessary for determination of the appeal.

The Director of ACO Contracting will review the written appeal and any information or documents submitted by the Participant or Preferred Provider and will confer with appropriate member(s) of OneCare's Workforce to assist in the appeal review process.
The Director of ACO Contracting[1] will facilitate and finalize the Level 1 Appeal determination.

The ACO will issue a written decision to grant or deny the appeal within sixty (60) calendar days of receipt of the written appeal from the Participant or Preferred Provider, or receipt of any additional information or documentation submitted by the Participant or Preferred Provider pursuant to a request from the ACO, whichever is later. The decision will include the supporting rationale and will set forth any actions that are to be taken by the Participant or Preferred Provider in accordance with the decision.

If the Participant or Preferred Provider is not satisfied with the ACO's decision, the Participant or Preferred Provider may request reconsideration through a Level 2 Voluntary Appeal.

B. Level 2 Voluntary Appeal:

A Participant or Preferred Provider may submit a Level 2 Voluntary Appeal in writing no later than ninety (90) calendar days after the date of the ACO's written decision on the Level 1 Appeal. The ACO's Appeals Committee ("Committee") will determine whether to grant or deny the Level 2 Voluntary Appeal. Any materials reviewed in conjunction with the Level 1 Appeal will be provided to the Committee for review and consideration in making a determination on this appeal. The Participant or Preferred Provider may also submit additional relevant information or documents to the Appeals Committee for review and consideration. The ACO will provide written acknowledgement of its receipt of the Level 2 Voluntary Appeal within fifteen (15) business days of receiving it.

The Appeals Committee shall consist of the ACO's Chief Medical Officer, Chief Operating Officer, Chief Financial Officer/Vice President of Finance, and Senior Director of Finance.[2] The Committee may also designate any member(s) of OneCare's Workforce who may have knowledge or expertise relevant to the

[1] Should the Director of ACO Contracting be unavailable for any reason to timely participate in the Level 1 Appeal process, the COO shall designate an alternate member of the ACO's leadership team with sufficient knowledge and experience to serve in this role.

[2] Should any of these Officers or Directors be unavailable for any reason to timely participate in the Level 2 Voluntary Appeal, the COO shall designate an alternate member of the ACO's leadership team with equivalent knowledge, experience, and expertise as that of the unavailable Officer(s) or Director to serve on the Committee in this role.

subject of the appeal as additional members of the Committee to participate in the review and determination of the appeal. The Appeals Committee may not designate the Director of ACO Contracting as an additional member, however it may request relevant factual information from that individual.

The Participant or Preferred Provider may request a meeting ("Meeting"), either by telephone or in-person, with a panel of at least three (3) members of the Appeals Committee ("Panel") to discuss the subject of the appeal and any materials submitted for consideration by the Committee. The Panel will summarize the contents of the Meeting for any members of the Committee who were not present.

The ACO and the Participant or Preferred Provider will make good-faith efforts to schedule a mutually-agreeable date and time for the Meeting to occur that is within forty-five (45) calendar days of the ACO's receipt of the Level 2 Voluntary Appeal. If, despite good-faith efforts, the parties are unable to agree upon a date and time for the Meeting to occur within this timeframe, the Participant or Preferred Provider may opt to: (1) forgo the meeting; or (2) request an extension of time to conduct the Meeting pursuant to the guidelines set forth below. The Participant or Preferred Provider must request such an extension in writing prior to the expiration of the forty-five (45) calendar day window for the Meeting, otherwise the Participant or Preferred Provider will be deemed to have opted to forgo the Meeting.

The ACO will issue a written decision to grant or deny the Level 2 Voluntary Appeal within sixty (60) days of the latest of: (1) the date the ACO is in receipt of all information and documents submitted by the Participant or Preferred Provider for review by the Appeals Committee; (2) the date the Meeting expires; or (3) the date the Meeting occurs. The ACO's written decision will include the rationale supporting it and will set forth any actions that are to be taken in accordance with the decision.

C. Appeal Extension Guidelines

The Participant or Preferred Provider may make a written request for an extension of any timeframe set forth in this Policy. Any such request must include the reason for making the request and a reasonable estimate of the additional time needed. The ACO may, in its sole discretion, grant this request under the following circumstances: (1) the information or documents supporting the appeal are voluminous and/or complex such that additional time is required for review; (2) information or documents in the possession of third parties, or witnesses with relevant factual knowledge of the subject of the appeal, that are necessary for making a reasonable determination to grant or deny the appeal are not available within the prescribed timeframes, but will be available at a reasonable later date; or (3) the ACO and Participant or Preferred Provider, despite good-faith efforts, are unable to schedule the Meeting within the forty-five (45) calendar day window permitted, and the Meeting can be scheduled within a reasonable period of time outside of the window.

D. Effect of Appeal Decisions

All decisions by the ACO to grant or deny a Level 2 Voluntary Appeal are final. A Participant or Preferred Provider must exhaust the appeals process set forth in the Policy before seeking resolution of the dispute through another process that may be required or permitted under the terms of the relevant Participant or Preferred Provider Agreement with the ACO.

E. Contact Information for Submission of Appeals:

OneCare Vermont Accountable Care Organization, LLC
Attn: Participant Appeals
356 Mountain View Drive, Suite 301
Colchester, Vermont 05446

Review Process: This Policy will be monitored to ensure it remains in alignment with all Program Agreements between ACO and Payers.

References: N/A

Related Policies/Procedures: N/A

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

Management Approval:

_____

Director, ACO Contracting Date

_____

Chief Operating Officer Date

_____

Chief Compliance Officer Date

Board of Managers Approval:

_____

Chair, OneCare VT Board of Managers Date

OneCare Vermont Accountable Care Organization
Board of Managers Resolution
Adoption of Policies

May 19, 2020

BE IT RESOLVED by the Board of Managers (the "Board") of OneCare Vermont Accountable Care Organization, LLC ("OneCare") as follows:

The Board, having reviewed, considered and discussed, hereby approves the following Polices:

A. 04-14 – Performance Year 2021 Risk Program Participation Policy

B. 05-01 – Contract Management Policy

C. 05-12 – Participant Appeals Policy

Public Affairs Report
May 2020

Media Coverage

CHCS Interview with OneCare CEO Vicki Loner

Center for Health Care Strategies, Inc. spoke recently with CEO Vicki Loner about OneCare's COVID-19 response, which included the rapid ramp-up of telehealth capacity in Vermont and how payment reforms in the state supported the ACO's ability to take action swiftly. Read the whole conversation in CHCS's post, "OneCare Vermont's Response to COVID-19: Supporting Telehealth Ramp-Up via Flexible Payment Strategies."

OneCare COVID-19 Application Featured in Bi-State Primary Podcast

This week's episode of Bi-State Primary Care Association's podcast, Policy in Plainer English, features OneCare's COVID-19 application and its impact on patient outreach during the pandemic. OneCare director of value-based care Tyler Gauthier describes the application and its use by health care organizations.

Government Relations

State Legislature

Vicki Loner testified at the April 10 Senate Health and Welfare Hearing on OneCare's response to the pandemic. Vicki detailed the advocacy work happening at the state, federal, and payer level to provide finanical relief to providers and to protect them from penalties. The committee noted the importance of fixed prospective payments during a time of rapid change in care delivery.

OneCare signed on to a letter from the health care provider association coalition to the chairs of the Senate Health and Welfare and House Health Care Committees asking for an extension of Act 91 flexibilities through FY 2021. Many of the provisions of Act 91 are dependent on the state of emergency. The letter also requested a permanent statutory change to require payers to allow for audio-only telemedicine, in addition to continuing options for audio-only telehealth (sometimes referred to as "triage calls").

Green Mountain Care Board

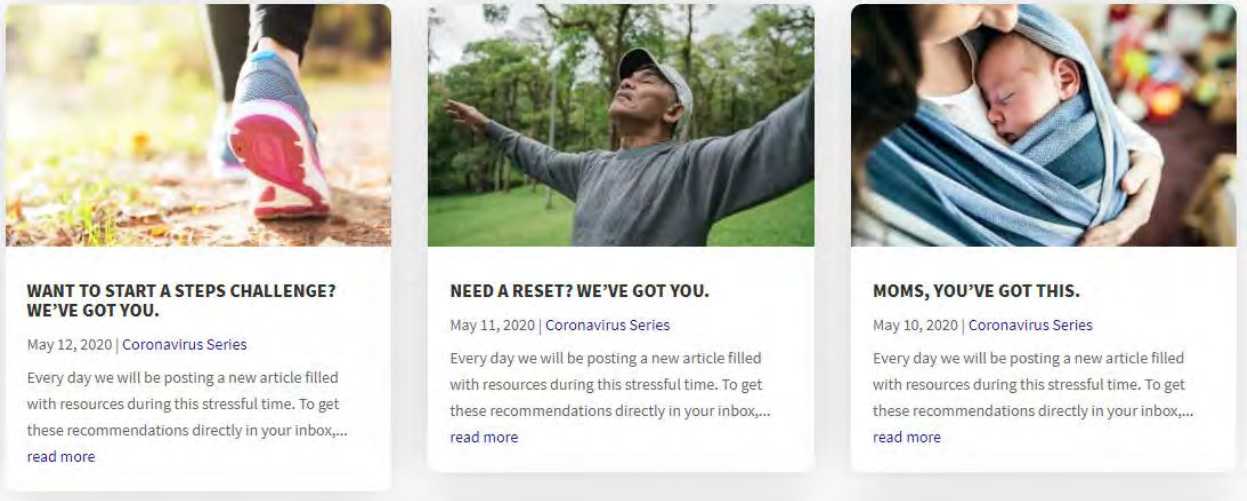
On April 22, Vicki Loner gave a presentation to GMCB describing OneCare's response to the pandemic and measures that OneCare is taking to provide financial relief to providers. OneCare is pursuing a multi-pronged strategy to support providers and Vermonters during the pandemic, including:

- Assuring stability, predictability, and flexibility in payments and programs to support providers.
- Advocating at the federal, state and payer level to reduce administrative burden, increase access to telehealth codes, holding providers harmless for performance and financial related penalties, and identifying additional funding/and or advancement opportunities for all participants.
- Developing and deploying new care coordination identification tools and care scripts to support Vermonters who are most vulnerable during the COVID-19 virus pandemic.

Network organizations have found that fixed payments for hospital and independent primary care provides stability and predictability when there are shifts in care delivery. Loner closed her presentation by stating that transitioning to a value-based system is an investment in Vermont's future, and that OneCare is driving a more consistent care model to provide the best care for all Vermonters.

Outreach and Advocacy

We've Got You Campaign



OneCare's primary prevention program, RiseVT, launched a community-based public wellness campaign to support the health and well-being of individuals and families who are at home during the pandemic. Each day, RiseVT is posting 5-7 activities, recipes, and health articles on social media channels including Facebook, Instagram, and Twitter. Mindfulness activities, opportunities to send gratitude to local helpers, art projects, and ways to connect with nature will also be shared. Please consider subscribing or visit the RiseVT blog to follow this robust social media campaign.

OneCare COVID-19 Blog Series

OneCare is working diligently to support the provider community and Vermonters during the COVID-19 pandemic in our COVID-19 blog category. Recent topics include the OneCare COVID-19 care prioritization application, a message from Vicki Loner about our response to the pandemic, and a telehealth webinar featuring CMO Norman Ward, MD.

COVID-19 and Mental Health Resources for Vermonters

OneCare developed a robust resources webpage for Vermonters in need of assistance during the pandemic. OneCare is committed to providing timely resources to support Vermonters and our community of health care providers during the COVID-19 pandemic. The resources are carefully curated to include public health information, suicide prevention, and mental health resources.

Rise to 5k

RiseVT started its statewide Rise to 5k Training virtually using Facebook Live and online media. RiseVT is offering a 10-week training program leading up to a RiseVT Virtual 5K on Saturday June 27 at multiple locations. This free event includes the following participant benefits:

- Written beginner training schedule
- Twice weekly Facebook live training session with our Bennington County Program Manager, Andrea Malinowski
- Weekly informational emails and handouts
- Nutritional and other tips to ensure success
- Virtual race day

Network Support Model

OneCare launched a new network support model to offer the network direct access to subject matter expert teams equipped to provide the network with specific ACO supports they need. Contact information and descriptions for each team can be found on the OneCare website here and in Network News.

Upcoming Events

Noontime Knowledge Session: TeleCare Connection

June 2, 12:00 pm - 1:00 pm

Our next Noontime Knowledge session will feature a presentation on the TeleCare Connection program. The University of Vermont Health Network Home Health & Hospice and Howard Center jointly created TeleCare Connection, an innovative program that delivers 24-hour remote support to individuals transitioning from the hospital to home. This session will include materials from a subject matter expert presenting on this important topic with time for questions and answers. This session is open to anyone; please share with those who may be interested. 1.0 CME/CEU offered for this session.

Vicki Loner presentation to Vermont Business Roundtable

(Date TBD)

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