# OneCare Vermont Accountable Care Organization, LLC
# Board of Managers Meeting Agenda

**June 16, 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*<br>*Vote to approve Consent Agenda items* | John Brumsted, MD |
| 4:33 p.m. | Governance<br>▪ Board Member Appointment<br>*Vote to approve Resolution Re-Appointing Board Members* | John Brumsted, MD |
| 4:40 p.m. | Public Affairs Update* | Vicki Loner |
| 4:45 p.m. | OneCare Policies*<br>▪ 02-04 "Community Care Coordination Program"* (New)<br>▪ 04-16 "Community Care Coordination Payments"*<br>*Vote to approve Resolution Adopting 2021 Community Care Coordination Program and Payments Policiess* | Sara Barry |
| 4:50 p.m. | Financial Management Policies and Resolutions Resolution*<br>▪ 04-06 "Disbursement Authority"*<br>*Vote to approve Financial Management Resolution for and Disbursement Authority Policy* | Tom Borys |
| 4:55 p.m. | 2019 Medicaid and BCBSVT QHP Quality Measure Performance | Tyler Gauthier |
| 5:05 p.m. | Telehealth Survey Results | Norman Ward, MD |
| 5:15 p.m. | Public Comment<br>Move to Executive Session | John Brumsted, MD |
| 6:55 p.m. | Votes<br>1. Approve Executive Session Consent Agenda items<br>2. Approve Resolution adopting OneCare Policies 07-02 Compliance; 07-07 Code of Conduct; and 07-08 Compliance Communication, Reporting and Investigation<br>3. Approve Resolution to Enter into Agreement with DVHA for DSR Funding Amending the VMNG Program Agreement | John Brumsted, MD |

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|---|---|---|
| | 4. Approve Resolution to Amend 2020 BCBS QHP Program Agreement<br>5. Approve Resolution Adopting Population Health Management Variable Payment Program for Performance Year 2021<br>6. Approve Resolution to Execute a Business Associate Agreement with PwC as Presented<br>7. Approve Resolution Adopting Revised 2020 Budget | |
| 7:00 p.m. | Adjourn | John Brumsted, MD |

*Denotes Attachments

**Attachments:**

1. Consent Agenda Items
    a. Draft of OneCare Board of Manager Minutes from May 19, 2020
    b. Board Committee Reports June 2020
    c. CMO Corner
2. Board Member Appointment Resolution *(forthcoming)*
3. June Public Affairs Report
4. OneCare Policies
    a. Summary of Policy Changes
    b. 02-04 Community Care Coordination Program
    c. 04-16 Community Care Coordination Payments
    d. Policies Resolution
5. Financial Management
    a. Financial Management Resolution
    b. Disbursement Authority Policy Summary
    c. 04-06 Disbursement Authority Policy
    d. Disbursement Authority Policy Resolution

# OneCare Vermont Accountable Care Organization, LLC
# Board of Managers Meeting
# May 19, 2020

## Minutes

A meeting of the Board of Managers of OneCare Vermont Accountable Care Organization, LLC ("OneCare") was held remotely via video and phone conference on May 19, 2020.

I. Call to Order

John Brumsted, M.D., called the meeting to order at 4:32 p.m.

II. Consent Agenda Items

A motion to approve the consent agenda items was made by T. Keating, seconded by B. Davis and approved by a unanimous vote.

III. Governance

Chair Brumsted stated that the Executive Committee recommends three nominees for the Patient Family Advisory Committee. Dr. Susan Shane, Medical Director, described the credentials of the nominees and the valuable perspectives they can bring to the Committee. A motion to approve the nominees was made by B. Davis, seconded J. Sayles and approved by a unanimous, supermajority vote.

Chair Brumsted noted that the Audit Committee charter has been developed and submitted for the Board's approval. Dan Bennett has been nominated as Chair of the Committee. A motion to approve the charter and Mr. Bennett as chair was made by T. Keating, seconded T. Dee and approved by a unanimous, supermajority vote.

IV. Network Telemedicine

Dr. Shane, stated that due to the COVID-19 situation there has been an increase in the usage of telemedicine. A telehealth survey was created and distributed to the network on May 18 to help evaluate the impacts. To date there have been 250 responses. The results will be analyzed and then discussed at the June 1 Population Health Strategy Committee meeting. The analytics team is also reviewing usage of telemedicine services.

V. OneCare Policies

Sara Barry, Chief Operating Officer, provided a summary of revisions to policies that require approval from the Board. Policy 04-14, "Risk Program Participation" was revised for Program year 2021 to 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 all risk programs.

Policy 05-01 "Contract Management" is a new and a uniform policy for the drafting, review, approval, management and retention of all OneCare contracts. The policy describes contracting accountabilities of the Director of ACO Contracting or designee, legal counsel, and Responsible Officers and established forms such as a Legal Review form to be completed in the contracting process and provides guidelines for contract provisions.

Policy 05-02 (formerly 06-12) "Participant Appeals" was updated to reflect recent updates to leadership responsibilities and accountability.

A motion to approve the policies was made by Dr. S. Leffler, seconded S. Lowell and approved by supermajority vote.

VI. Public Comment

There were no members of the public in attendance.

VII. Executive Session

Motion to move to Executive Session was made by Dr. S. Leffler, seconded J. Peterson.

VIII. Voting

1. Executive Session Consent Agenda items - **Approved**
2. Resolution to submit application to the IRS for recognition as a 501(c)(3) organization together with supporting documentation including:
    - Second Amended and Restated Articles of Organization, which shall also be filed with the Secretary of State and
    - 8th Amended and Restated Operating Agreement – **Approved by supermajority**
3. Resolution to enter into Blue Cross Primary Agreement Materially Consistent with Terms Presented - **Approved**
4. Motion for the Population Health Management Committee to further review the 2021 Population Health Management and Risk Sharing Policy - **Approved**
5. Resolution adopting 2021 VBIF Policy - **Approved**
6. Resolution adopting revised 2020 Participant Dues and Participant Fixed Payment Policies - **Approved**

IX. Adjourn

Upon a motion made and seconded, the meeting adjourned at 6:32 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 | ☒ Sally Kraft, MD | ☒ Judy Peterson |
| ☒ Tom Dee | ☒ Todd Keating | ☒ Toby Sadkin, MD |
| ☐ Claudio Fort | ☒ Steve LeBlanc | ☒ John Sayles |

☒ Steve Gordon ☒ Steve Leffler, MD

OneCare Risk Strategy Committee

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

OneCare Leadership and Staff

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

# OneCare Board of Manager Committee Report-Outs June 2020

***Executive Committee (meets monthly)***
*At its June 4 meeting the committee continued to discuss the impact of the COVID-19 pandemic on network strategy. The committee discussed the purpose, frequency, and duration of its meetings and terms for members of the Board of Managers. The committee reviewed and discussed the revised 2020 budget for OneCare Vermont and the upcoming budget presentation to the Green Mountain Care Board.*

***Audit Committee (meets quarterly)***
*The committee is next scheduled to meet August 13, 2020.*

***Finance Committee (meets monthly)***
*At its June 10 meeting, the committee discussed considerations around Medicare Reinsurance. There were four policies and one resolution presented to the committee: HSA Benchmark Policy, PHM Policy, Care Coordination Policy, Disbursement Authority Policy and the Financial Management Resolution. The HSA Benchmark Policy will be brought back to committee in July for further discussion. BCBSVT QHP and Medicaid Program Amendments were shared with the committee. The 2020 Budget changes were shared and discussed along with a briefing on timing for 2021 budget estimates. The committee concluded the meeting with Medicare and Medicaid 2019 Settlements discussion.*

***Population Health Strategy Committee (meets monthly)***
*The June 1 committee meeting began with a discussion on the 2021 Population Health Management investment policy. The Care Coordination Program was presented. The Telemedicine Survey Results were shared with the members. The committee heard a summary of the 2019 Medicaid and BCBS QHP annual network quality results and discussed DVHA's proposed modifications to the Medicaid Prior Authorization Waiver. The next committee meeting is scheduled for July 7, 2020.*

***Clinical & Quality Advisory Committee (meets bi-monthly)***
*The June 11 committee meeting agenda consisted of a presentation on the New Care Coordination payment model, CPR Quality Project Report outs and the Telemedicine Survey Results. The VMNG Prior Authorization Waiver changes were presented and discussed. Committee members shared a few words on the COVID response and future state..*

***Patient & Family Advisory Committee (meets monthly)***
*At its June 9 meeting, the members heard a Patient Family Advisor Training presentation from Lisa Leblanc with the Patient and Centered Care Team with UVM Medical Center. The training centered around the role and responsibilities of the Patient and Family Advisor and the Patient- and Family-Centered care model. It defined patient- and family-centered care, recognized driving forces of patient- and family-centered care, shared tips for being and effective patient/family advisor, and discussed the art of listening.*

***Pediatric Subcommittee (meets bi-monthly)***
*This committee is scheduled to meet next on July 16, 2020. Agenda TBD.*

**OneCare Vermont Board of Managers**

**June 16, 2020**

**CMO Corner**

1. **Telehealth** – The industry interest in telehealth – current and future uses - continues to be one of the most important issues stemming from the COVID emergency. On May 29, 2020 OneCare met with the Vermont Program for Quality Healthcare, the Vermont Medical Society, and Blue Cross of Vermont to discuss grant opportunities to promote Connectivity Care Packages in Vermont. This concept involves acquiring hardware improving broadband and cell connectivity to permit delivery of telemedicine services to vulnerable individuals. Potential funding sources are the Federal Communication Commission and the US Department of Agriculture. On June 3, the VPQHC office hours welcomed the staff of all three of Vermont's congressional delegation. The link to this very informative recording is: https://www.vpqhc.org/statewide-telehealth-events

2. **Vermont Medicaid Next Generation Prior Authorization Waiver** – DVHA's proposed changes to the 2020 Prior Authorization Waiver service list was discussed at the June 1 Population Health Strategy Committee. The committee voted to endorse the changes to the program involving either continued, reinstituted, or delayed reinstitution of certain PA categories.

3. **Regional Clinician Representatives Recruitment** – OneCare is seeking willing clinicians to serve as RCRs in Burlington, Springfield, and Bennington. This is an excellent role for physician and advanced practice provider leaders to increase their knowledge of health reform, the OneCare Vermont ACO, and to communicate effectively with their local medical community.

4. **Noontime Knowledge** June 2 - – Representatives of the Howard Center and the University of Vermont Health Network Home Health and Hospice presented their innovative model of 24/7 coverage of selected patients whose ability to be discharged from hospital rests on putting in place sufficient support services in their homes – as an alternative to skilled nursing facility care. The model marries the overnight phone support of the designated agency with the daytime telehealth services of the home health agency.

5. **Springfield Health Service Area –** Dr. Ward presented to the QI Steering Committee of Springfield Medical Care System on June 1. The 2019 year end Performance Dashboard was reviewed and discussed in detail looking for opportunities to guide performance improvement.

6. **"Pearls and Pitfalls" Noontime Knowledge Chronic Disease Series -** a OneCare Vermont participant clinician survey will be sent out soon requesting the network's contributions of their favorite "clinical pearls" , "clinical pitfalls", and most pressing questions concerning diagnosis and management of six chronic diseases: diabetes, hypertension, chronic kidney disease, heart failure, COPD, and coronary artery disease. Expert panels will lead six noontime presentations to review these topics to promote improved clinical care.

# OneCare Vermont

## Public Affairs Report | June 2020

# Media Coverage

### Health Systems Bolstered by the All Payer Model


CEO Vicki Loner was interviewed by **WCAX** in a feature describing how the move to fixed payments buoys hospitals during times of crisis, including the COVID-19 public health emergency. Fixed payments received by hospitals and health systems "provided them with consistent cash flow and the ability to be more nimble," said Loner. Continuing to reform the healthcare system will help Vermont weather future times of instability. Watch and read the story here.

### Impact of COVID-19 on Hospitals and the All Payer Model

**VTDigger** featured an op-ed by Richard Slusky describing how the terms of the all-payer model waiver agreement supports hospitals in providing a steady stream of revenue even when services decline, such as during the current state of emergency. Slusky stated, “Under a fully implemented all-payer model agreement, the hospitals would have continued to receive most of their payments under a fixed payment/global budget contract and would have been in a much better position to fund the additional costs related to the coronavirus.” Read the full story.

Emerson Lynn responded in an op-ed in the St. Albans Messenger entitled “It can be salvaged, made better.” Lynn emphasized the importance of the all payer model in shifting from fee-for-service to stable, predictable payments, and the need for more organizations to join the model to create true health care reform. “If the all payer model comes crumbling down, then we are left with the same failed

system we had prior. The all payer model is based on wellness and health care prevention. The health care profession benefits as the population becomes healthier. It no longer becomes a goal to see how many times a patient can be scheduled for treatment."

### The Moment is Here

**VTDigger** featured an op-ed by Tomasz Jankowski naming the moment of opportunity our country has due to the global pandemic and the senseless killings of Black Americans at the hands of police. The confluence of these factors has laid bare systemic inequality. "We must, more than ever before, exercise compassion, empathy, and civility with each other in order to build culture of shared trust, respect, understanding, and safety," says Jankowski. Read the full story.

### Mental Health Providers Report Surge in Call Volume

**WCAX** reported that mental health professionals are seeing an uptick in calls for help due to the pandemic, referred to as "COVID fatigue" by Mary Moulton, executive director of Washington County Mental Health Services. Anxiety and depression are on the rise due to the impact quarantine and social distancing have had on daily routines and finances. After months of sheltering at home, many people would like to get out, but some are afraid to do so. Read and watch the story.

### Vermont Department of Health Reports Decline in Immunizations

**NBC5** covered a decline in childhood immunizations reported by the Vermont Department of Health. The Vermont Department of Health has seen a decrease in the number of required immunizations children in Vermont received in April and May of 2020 compared to the same time period in 2019. These immunizations protect children against life-threatening illnesses and are required for school attendance. Pediatricians are encouraging families to catch up on immunizations. Dr. Leah Costello of Timber Lane Pediatrics said, "Your physician's office is a safe place to be to receive that routine care including these really lifesaving immunizations." Read and watch the story.

## Government Relations

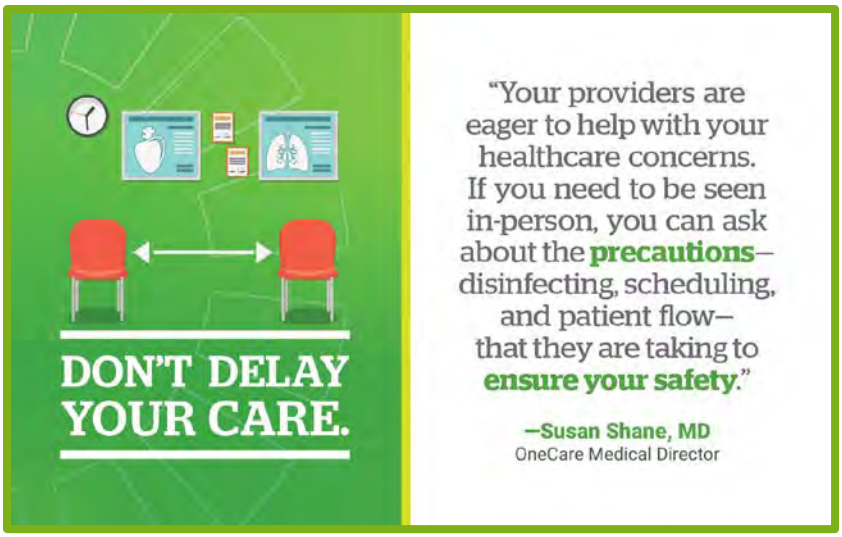
### Green Mountain Care Board

On June 3 the Green Mountain Care Board met to discuss the draft of the OneCare FY 2021 budget guidance and certification eligibility form. The budget guidance is currently undergoing GMCB legal review and the Board plans to vote on these documents on June 17. Public comment is currently open through June 16. OneCare expects to receive the final guidance and certification forms on July 1. There are no changes to the certification eligibility verification form and it is due on September 1, followed by OneCare's budget submission on October 1.

OneCare Leadership will provide a budget update to the GMCB on June 24.

## Outreach and Advocacy

### Don't Delay Your Health Care Campaign




During the COVID-19 pandemic, providers far and wide are sharing the same message: "Don't delay your health care," urging people not to put off obtaining health care out of fear of contracting the virus. Health care providers want Vermonters to stay healthy, are taking extensive measures to ensure patient safety, and creating new ways to make health care safe and accessible, including by offering telephone and video appointments. OneCare is passing on these important messages from our community of providers to Vermonters everywhere through our social media campaign.

**We'd love to include a message from you in this campaign.**
If you have a message to Vermonters about why not to delay health care, send a quote to Alice Wack, Marketing and Communications Strategist, at Alice.Wack@onecarevt.org.

## Presentation to Vermont Business Roundtable

On May 22, Vicki Loner, CEO, spoke to members of the Vermont Business Roundtable to provide an update on OneCare's response to the COVID-19 pandemic. She shared information on our COVID app and also discussed ways that we are working to get much needed cash flow to practices. Finally, when asked for suggestions on how the business community can support OneCare's efforts she asked for ideas on engaging employers and employees in the self-funded program.

## Interview with Duke University

Vicki Loner participated in an interview with the Margolis Center for Health Policy at Duke University related to the topic of ACOs and other healthcare organizations participating in value-based models leveraging their flexibilities during the COVID era. The interview took place on June 3 and Duke University plans to create and distribute an issue brief.

# Upcoming Events

## OneCare Care Coordination Training Series

**June - July 2020**

In support of the OneCare provider network's effort to improve care coordination for Vermonters, an educational series of care coordination related courses is being offered for frontline workers through the month of June. Members from the Care Coordination Team will present a different pertinent topic each week in a webinar during the noon hour. The presentation material will be about 30 minutes, with time for questions at the end. To register, email Honey Resto the dates of the sessions you would like to attend.

**You are the Lead Care Coordinator: Facilitating an Effective Care Team Conference**
June 17, 12:00 pm - 1:00 pm
Prepare and facilitate a patient- centered and strengths based care conference. Align goals and workflow, progress on goals in the shared care plan, assign team members for follow up care. More Information

**Words MATTER: Using Person Centered Language**
June 24, 12:00 pm - 1:00 pm
Understand and use person-centered language in care coordination. More Information

**Getting SMART About SMART Goals**
July 1, 12:00 pm - 1:00 pm
Outlines the importance of developing SMART goals and tasks in the context of shared care planning. More Information

## GMCB Budget Presentation

**June 24**
Vicki Loner and Tom Borys will present a revised 2020 budget to the Green Mountain Care Board. Meeting details can be found here.

# Follow Us

You can keep with OneCare on our blog, LinkedIn, and Twitter (@OnecareVermont).
We would greatly appreciate it if you like and share our content - help us spread awareness.

# Board of Managers Policy Summary

## Public Session

*June 2020*

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

- **02-04 Community Care Coordination Program** *(New Policy)*
  - **Description:** Defines the foundational concepts and responsibilities associated with OneCare's Community Care Coordination Program.
  - **Key Features:** This policy provides a high level description of the OneCare Community Care Coordination program including:
    - Overall approach to care coordination and goal of creating a system of care in which all Vermonters have access to high quality, evidence-informed, interdisciplinary, community-based care coordination across the continuum
    - Population Health Model and risk stratification methods
    - Purpose and benefits of Care Navigator
    - High level OneCare and network participant responsibilities including outreach, care coordination activities, analytics, and monitoring

- **04-16 Community Care Coordination Payments**
  - **Description:** Defines key components and expectations of the Care Coordination program that drive payments for new and existing eligible Participants, Preferred Providers and Collaborators.
  - **Key Changes:**
    - Language was broadened to apply supplemental payments to all risk levels with documented clinical rationale
    - Addition of a cap on supplemental payments to be determined by the Board prior to the start of the performance year with input from Population Health Strategy Committee
    - Payment mechanism and amount provided to newly contracted members was changed to streamline support for initial ramp-up of Primary Care Providers ($3,000 per month for nine months)
    - Means of communication to network regarding program expectations shifted from a letter-based communication to the OneCare Care Coordination Payment Model Guidance Document which has been seen as a valuable tool in 2020
    - No changes in PMPM or PMPY payments or core activities that trigger payments

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|---|---|
| **Policy Number & Title:** | 02-04 Community Care Coordination Program Policy PY 2021 |
| **Responsible Department/s:** | Clinical |
| **Author:** | Jodi Frei, Manager of Clinical Programs |
| **Date Implemented:** | 01/01/2021 |
| **Date Reviewed/Revised:** | N/A |
| **Next Review Date:** | 03/01/2021 |

**I. Purpose:** A policy for defining the foundational concepts and responsibilities associated with OneCare's Community Care Coordination Program.

**II. Scope:** This policy applies to all OneCare Participants, Preferred Providers and Collaborators (collectively "Network") participating in Care Coordination interventions performed for Attributed Lives.

**III. Definitions:**

Terms used in this Policy that are not defined are intended to have the meaning ascribed in OneCare's Policy Glossary.

ACO Program refers to a program between the ACO and a Payer for ACO Activities and value based payment arrangements.

Attributed Life/Lives refers to Individual(s) that receive healthcare benefits from a Payer in an ACO Program and are attributed to ACO in accordance with the terms of an ACO Program Agreement.

Care Conference refers to a meeting of health care professionals and representatives of supporting social services organizations who are members of the Care Team of a Care Managed Attributed Life where Care Coordination is actively evaluated, conducted, and documented in Care Navigator. A Care Conference must include representatives of multiple Participant, Preferred Provider and/or Collaborator organizations, a meeting of only a single Network member will not qualify as a Care Conference.

Care Coordination refers to the deliberate organization of patient care activities and sharing of information among all of the health care professionals and representatives of supporting social services organizations concerned with a patient's care. The goal is to achieve 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 Navigator refers to OneCare's care coordination software platform designed to improve communication among Care Team members. It includes patient demographic and utilization data, assessments, Shared Care Plans, and notes/tasks to support engagement in care coordination. Care Navigator is the data source to identify payments to Participants, Preferred Providers and Collaborators under this policy, documentation in Care Navigator is required for payment

Care Team refers to individuals with the appropriate training, skills, and abilities, who work collaboratively to support the patient's identification and achievement of goals for his/her care. Care Team members assist with task identification and completion, identify and remove barriers, and work cross-organizationally to promote whole-person care. Care Team members may include primary and specialty care providers, care coordinators, case managers, social workers, nurses, nutritionists, mental health counselors, or other professional and lay staff of Network members.

Collaborator is an individual or entity that has entered into a Collaboration Agreement with OneCare to: (i) provide for, (ii) arrange for, or (iii) manage health care services and/or social support services in the ACO service area, or to otherwise support the activities and goals of the ACO.

Encounters refers to interactions with a Care Managed individual for the purposes of Care Coordination. Participants, Preferred Providers and Collaborators are expected to document key patient encounters in Care Navigator in order to support the coordination of care and services across organizations. Encounters can be in-person in a variety of settings (e.g. office, facility, home, community setting) or virtual such as telehealth, phone calls or substantive written communications. Encounters include, but are not limited to: primary care visits, specialist visits, home visits supporting coordination of care, transitions of care interactions, participation in self- management programs, and participation in community-based events.

Guidance Document refers to the set of Care Coordination criteria and specifications as approved by the Population Health Strategy Committee.

Johns Hopkins Adjusted Clinical Groups (AGC) Risk Score is a prospective risk score that uses risk factors from the current one-year time period to predict total cost and risk for morbidity for the patient in the subsequent one-year time period. Specific risk factors, based on age, gender, diagnosis data (based on ICD9/ICD10 diagnosis codes), and pharmacy data, are determined for each patient by the ACG system.

Lead Care Coordinator refers to the professional on a Care Team whom a patient designates to take primary responsibility for organizing his/her care activities, creating the Shared Care Plan, scheduling and creating the agenda for Care Conferences, sharing information and delegating responsibilities in a clear fashion. The Lead Care Coordinator must be employed by or contracted by a Network member and must: (1) hold the appropriate credentials as outlined in the Guidance Document; or (2) ensure such credentials are maintained by one or more other active Care Team members and all other conditions of the Guidance Document are met.

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

Shared Care Plan refers to a structured tool used to identify and document (1) a patient's goals, barriers, and strategies with the Care Team member(s) responsible for each; (2) the timeframe for achieving goals and (3) the patient's prioritization of these goals/activities. A Shared Care Plan is used to facilitate the communication of information needed to coordinate across Care Team members. A Shared Care Plan is created when two goals and two tasks per goal are documented and regularly updated in Care Navigator to meet the expectations of the Care Coordination Model. A Shared Care Plan should be routinely reviewed by the Lead Care Coordinator with the patient and appropriate Care Team members and updated as needed.

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

## IV. Policy

### A. OneCare Community Care Coordination Program Background and Foundational Concepts

OneCare promotes a decentralized, community-based approach for care coordination service delivery with the intent of creating a system of care in which all Vermonters have access to high quality, evidence-informed, interdisciplinary, community-based care coordination across the continuum. The OneCare Population Health Care Model, data driven risk stratification processes, and a centralized

Care Coordination team guide these efforts. The OneCare Population Health Care Model segments populations into the following categories:

Category 1: Healthy / well majority (low)
Category 2: Early onset / stable chronic illness (medium)
Category 3: Full onset chronic illness and rising risk (high)
Category 4: Complex / catastrophic high cost (very high)

Segmentation into these categories is achieved through risk stratification using the Johns Hopkins Adjusted Clinical Groups (AGC) risk scores. A risk rank is generated and thresholds are drawn:

Very High Risk – the top 6% of the population with the highest risk rank (i.e. >94%-100%)
High Risk – the next 10% of the population by risk rank (>84%-94%)
Medium Risk – the next 40% of the population by risk rank (>44%-84%)
Low Risk – the 44% of the population with the lowest risk rank (0%-44%)

These risk/care coordination levels identify individuals that may benefit from Care Coordination interventions and supports to improve their health and wellbeing as well as to address the total cost of care for individual and the attributed population. An individual's care coordination level is set annually, but may be overridden based on clinical judgement as permitted by this policy. Generally, 15% of High and Very High Risk patients benefit from and should be engaged in Care Coordination, although this may vary by ACO Program. Others, as deemed by clinical judgement, may benefit from being engaged in Care Coordination as well.

OneCare provides a communication platform, Care Navigator, as a means of cross-organizational collaboration. Patients may view their Shared Care Plan from within this platform. Access to Care Navigator is driven by privacy and security rules and regulations as well as data use agreements. The Health Service Area target rate for a care managed individuals is 15% of the High and Very High Risk population. An individual is considered care managed when a Lead Care Coordinator and Shared Care Plan with two active goals and two associated tasks per goal are documented and updated regularly within Care Navigator.

Performance insights including Care Coordination rates, gaps in care, quality measure performance, and trends in ED utilization and hospital readmissions, are used to support the growth and direction of health service area and ACO wide Care Coordination efforts.

B. **Actions/Responsibilities**

<u>OneCare:</u>

- OneCare provides prospective medical, financial, and social determinants of health risk information to the Network to identify and prioritize outreach for Care Coordination.
- OneCare provides performance reports and self-service applications within WorkBenchOne, OneCare's Enterprise Data Warehouse, to support ongoing process metrics and outcomes monitoring.
- OneCare's Care Coordination team supports the Network by delivering evidence informed training and education programs, facilitating meaningful use of Care Navigator, and supporting evidence-informed care coordination practices.
- OneCare's clinical team will conduct quality assurance reviews to assess the Care Coordination procedures, process metrics, and adherence to guidelines in that Health Service Area and/or in any participating TINs. This is in addition to audits of the Care Coordination Payment Model monitored under separate OneCare policy.

- OneCare and its Population Health Strategy Committee review trends in overall utilization, costs of care, and health outcomes and recommend refinements or enhancements to the Board of Managers to continuously improve Care Coordination processes and systems.
- OneCare's Utilization Review Committee and its workgroups on finance, quality and utilization management conduct regular assessments of performance, gaps in care, and variation across health service areas to monitor performance and identify opportunities to strengthen systems of care in support of complex care outcomes.

Network Participants, Preferred Providers and Collaborators:

- Network Participants, Preferred Providers and Collaborators work collaboratively to develop and refine internal and cross-organizational workflows to facilitate effective, evidence informed care coordination for Attributed Lives.
- Network Participants, Preferred Providers and Collaborators designate a resource whose role it is to regularly review their panel of High and Very High Risk Attributed Lives in order to perform outreach and engage them in care coordination. These designated resources meet training and documentation expectations outlined in Program of Payments and Care Coordination Payment Model Guidance Document.
    - Expected outreach for patients not engaged in Care Coordination varies by need and should be impacted by clinical judgement and availability of information on new or changing circumstances, but must be at minimum monthly for High and Very High Risk Attributed LIves until such a time as an Attributed Life either engages in Care Coordination or declines participation. Engagement or declination is documented in Care Navigator.
    - Minimum expected outreach for Attributed Lives engaged in Care Coordination:
        Very High Risk – 12 times per year (i.e. monthly)
        High Risk – 4 times per year (i.e. quarterly)
        Medium Risk – 2 times per year (i.e. biannually)
        Low Risk– 1 time per year (annually)
- Care Coordination services are implemented using a patient centered, multidisciplinary, community based approach. Attributed Life wishes are respected and team members from various organizations serving the Attributed Life collaborate to best meet the individual's needs and goals in an effective and efficient manner.
- Care Coordination services include but are not limited to performing Lead Care Coordinator responsibilities when designated by the Attributed Life developing and contributing to patient centered Shared Care Plans, and participating in cross-organizational care teams and care conferences.
- Care Coordination activities and interactions are documented within Care Navigator. This includes but is not limited to designated Lead Care Coordinator, Care Team members, Shared Care Plans, Care Conferences, and Encounters.
- The aforementioned Network responsibilities are high level and entail specific criteria, actions and documentation outlined in the OneCare Care Coordination Payment Model Guidance Document approved by the OneCare Population Health Committee shared with the Network at least annually. Each Health Service Area will have access to supports from OneCare's Care Coordination team in order to assure program responsibilities are met.

**V. Review Process:** This policy shall be reviewed periodically and updated to be consistent with requirements set forth by OneCare Board of Managers, OneCare Leadership and regulatory bodies.

**VI. References:**

- Care Coordination Payment Model Guidance Document, OneCare Vermont/Clinical Unit/Care Coordination Team/Care Coordination Payment Model
- Program of Payment, OneCare Vermont/Operations/ACO Payer Programs/Network Agreements and Outreach

**VII. Related Policies/Procedures:**

- 02-02 Community Care Coordination Payment Policy
- C02-05 Care Coordination & Disease Management Program within an Integrated Care Delivery Model Procedure
- Quality Assurance Procedure (In development)

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

**Management Approval:**

| | |
|---|---|
| Director, Care Coordination and Clinical Programs | Date |
| Director, Value Based Care | Date |
| Chief Medical Officer | Date |
| Chief Operating Officer | Date |

**Board of Managers Approval:**

| | |
|---|---|
| Chair, OneCare Vermont Board of Managers | Date |

| | |
|---|---|
| **Policy Number & Title:** | 04-16 Community Care Coordination Payments PY 2021 |
| **Responsible Department/s:** | Finance, Analytics, Clinical |
| **Author:** | Jodi Frei, Manager of Clinical Programs |
| **Date Implemented:** | 07/01/2017 |
| **Date Reviewed/Revised:** | 06/01/2020 |
| **Next Review Date:** | 03/01/2021 |

**I. Purpose:** A policy for calculating, distributing, suspending or terminating Community Care Coordination payments to OneCare Network Participants, Preferred Providers and Collaborators in accordance with OneCare Vermont's (OneCare) Care Coordination Model.

**II. Policy Statement:** This Policy describes the ways Participants, Preferred Providers and Collaborators (collectively "Network") are paid by OneCare for performing Community Care Coordination activities for defined populations. Community Care Coordination activities are described in ACO Program Agreements, Participant/Preferred Provider Agreements, or Collaborator Agreements, in the OneCare Care Coordination Program Policy, and in the Care Coordination Payment Model Guidance Document distributed, at a minimum, annually to the designated contact people for Network members.

**III. Definitions:**

Terms used herein that are not defined are defined in OneCare's Policy Glossary and shall have the meaning ascribed in that Glossary.

ACO Program refers to a program between the ACO and a Payer for ACO Activities and value based payment arrangements.

ACO Program Agreement refers to a written agreement between ACO and a Payer

Attributed Life refers to an individual that receives healthcare benefits from a Payer in an ACO Program and is attributed to ACO in accordance with the terms of an ACO Program Agreement.

Care Coordination refers to the deliberate organization of patient care activities and sharing of information among all of the health care professionals and representatives of supporting social services organizations concerned with a patient's care. The goal is to achieve 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 Conference refers to a meeting of health care professionals and representatives of supporting social services organizations who are members of the Care Team of a Care Managed Attributed Life where Care Coordination is actively evaluated, conducted, and documented in Care Navigator. A Care Conference must include representatives of multiple Participant, Preferred Provider and/or Collaborator organizations, a meeting of only a single Network member will not qualify as a Care Conference.

Care Team refers to individuals with the appropriate training, skills, and abilities, who work collaboratively to support the patient's identification and achievement of goals for his/her care. Care Team members assist with task identification and completion, identify and remove barriers, and work cross-organizationally to promote whole-person care. Care Team members may include

primary and specialty care providers, care coordinators, case managers, social workers, nurses, nutritionists, mental health counselors, or other professional and lay staff of Network members.

Care Managed refers to having a Lead Care Coordinator, identified by the patient, and a Shared Care Plan documented in Care Navigator with active goals and tasks as defined in the Guidance Document.

Care Navigator refers to OneCare's care coordination software platform designed to improve communication among Care Team members. It includes patient demographic and utilization data, assessments, Shared Care Plans, and notes/tasks to support engagement in care coordination. Care Navigator is the data source to identify payments to Participants, Preferred Providers and Collaborators under this policy. Documentation in Care Navigator is required for payment

Collaborator is an individual or entity that has entered into a Collaboration Agreement with OneCare to: (i) provide for, (ii) arrange for, or (iii) manage health care services and/or social support services in the ACO service area, or to otherwise support the activities and goals of the ACO.

Encounters refers to interactions with a Care Managed individual for the purposes of Care Coordination. Participants, Preferred Providers and Collaborators are expected to document key patient encounters in Care Navigator in order to support the coordination of care and services across organizations. Encounters can be in-person in a variety of settings (e.g. office, facility, home, community setting) or virtual such as telehealth, phone calls or substantive written communications. Encounters include, but are not limited to: primary care visits, specialist visits, home visits supporting coordination of care, transitions of care interactions, participation in self- management programs, and participation in community-based events.

Guidance Document refers to the set of Care Coordination criteria and specifications as approved by the Population Health Strategy Committee.

High and Very High Risk Attributed Lives refers to the patient cohort that has been defined in the ACO Program by risk stratification. Generally, this is the top 16% of Attributed Lives however, this may vary by ACO Program.

Lead Care Coordinator refers to the professional on a Care Team whom a patient designates to take primary responsibility for organizing his/her care activities, creating the Shared Care Plan, scheduling and creating the agenda for Care Conferences, sharing information and delegating responsibilities in a clear fashion. The Lead Care Coordinator must be employed by or contracted by a Network member and must: (1) hold the appropriate credentials as outlined in the Guidance Document; or (2) ensure such credentials are maintained by one or more other active Care Team members and all other conditions of the Guidance Document are met.

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

Primary Care Provider refers to a health care provider who meets the criteria of an ACO Program for a Primary Care Provider. This is generally a physician (and for certain ACO Programs a Nurse Practitioner or Physician Assistant) whose specialty is internal medicine, geriatrics, family practice, pediatrics or naturopathy; a Federally Qualified Health Center or a Rural Health Center.

Shared Care Plan refers to a structured tool used to identify and document (1) a patient's goals, barriers, and strategies with the Care Team member(s) responsible for each; (2) the timeframe for achieving goals

and (3) the patient's prioritization of these goals/activities. A Shared Care Plan is used to facilitate the communication of information needed to coordinate across Care Team members. A Shared Care Plan is created when two goals and two tasks per goal are documented and regularly updated in Care Navigator to meet the expectations of the Care Coordination Model. A Shared Care Plan should be routinely reviewed by the Lead Care Coordinator with the patient and appropriate Care Team members and updated as needed.

Supplemental Care Coordination Payments refers to payments that are made to Participants, Preferred Providers and Collaborators by OneCare to support Care Coordination activities that generally do not receive reimbursement from Payers.

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

## IV. Policy

### A. Supplemental Care Coordination Payments

1. For Primary Care Preferred Providers and Participants that were not contracted with OneCare in the prior year for any ACO Program:

   OneCare will make a monthly care coordination capacity payment of $3000 for the first nine months of the calendar year. This payment is for the purposes of allowing adequate time for the primary care office to become acquainted with the ACO Programs, and ramp up care coordination activities. After this initial nine month period, primary care Preferred Providers and Participants will transition into the payment model set forth in 2 below.

2. For Participants, Preferred Providers and Collaborators that were contracted with OneCare in the prior year for any ACO Program:

   OneCare will make monthly payments up to a total monetary cap for Supplemental Care Coordination. The cap will be approved by OneCare's Board of Managers prior to the start of the Performance Year. The Population Health Strategy Committee shall consider the Community Care Coordination program and make recommendations to the Board of Managers for implementing and evaluating the cap.

   Care Coordination Payments are based on care coordination activity as described below. Payments made for Care Coordination activity performed in January, February and March will be based on the prior Performance Year's cohort of Attributed Lives. Payments made for Care Coordination activity performed in April through December will be based on the current Performance Year cohort of Attributed Lives.

   All payments, up to the cap, will be made the month after qualifying data is documented in Care Navigator. By way of example, August activity will be paid in the month of September.

   Payments will be made as follows:

   a. Lead Care Coordinator Per Attributed Life Per Month (PMPM) Payments:
      OneCare will pay $80.00 PMPM to the Participant, Preferred Provider or Collaborator that establishes a Lead Care Coordinator relationship and a Shared Care Plan with an Attributed Life and documents these events in Care Navigator to OneCare's reasonable

satisfaction. The $80.00 PMPM can be earned beginning in the month the Lead Care Coordinator and Shared Care Plan are designated in Care Navigator. When a Lead Care Coordinator becomes inactive, as defined in the Guidance Document, because of the patient's location, condition, willingness to participate in Care Coordination Program or any other reason, it is expected that the team member will remove him/herself from the care team in Care Navigator in a timely manner.

b. Care Team Per Member Per Month Payments:
OneCare will pay $60.00 PMPM to any Participant, Preferred Provider or Collaborator who participates in the Care Team, but is not a Lead Care Coordinator, and documents their active Care Team participation in Care Navigator. The $60.00 PMPM is effective the month the Care Team member is designated in Care Navigator for an actively Care Managed patient. In the unusual instance that a Lead Care Coordinator and a Care Team member are from the same Primary Care Provider TIN, representatives from at least one other organization must participate on the Care Team for the TIN to be eligible for the Care Team member payment. When a Care Team member becomes inactive, as defined in the Guidance Document, because of the patient's location, condition, willingness to participate in Care Coordination Program or any other reason, it is expected that the team member will remove him/herself from the care team in Care Navigator in a timely manner.

c. Care Conference – Lead Care Coordinator Per Attributed Life Per Year (PMPY)
A $300.00 PMPY payment will be made to a Participant, Preferred Provider or Collaborator when the Attributed Life's Lead Care Coordinator conducts a Care Conference for that Attributed Life.

d. Care Conference – Care Team PMPY
A $150.00 PMPY payment will be made to a Participant, Preferred Provider or Collaborator when the Attributed Life's Care Team member participates in a Care Conference for that Attributed Life.

**B. Monitoring**

OneCare's clinical team will conduct routine quality assurance reviews and initiate audits as appropriate in OneCare's reasonable judgment to insure the integrity of the Community Care Coordination program and associated payments. Participants, Preferred Providers and/or Collaborators assigned to a TIN and/or Health Service Area who receive Supplemental Payments may be required to participate in reviews and/or audits. The purposes of the audit may include, but are not limited to, assessing the Care Coordination procedures, adherence to guidelines, process metrics, and outcomes achieved in that Health Service Area and/or in any participating TINs receiving Supplemental Care Coordination Payments through OneCare. The audit may result in confirmation of results and continuation of payments, possible expansion of payments, reduction in payments, or corrective action, which may include a corrective action plan or other remedies such as repayment.

1. **Stopping or Suspending Payments**: OneCare may suspend or stop Care Coordination Program payments under the following circumstances:
    - The Participant, Preferred Provider or Collaborator is no longer participating in the OneCare Community Care Coordination program, or
    - The Participant, Preferred Provider or Collaborator is not complying with the program's requirements and/or expectations as contained in its Agreements

with OneCare and applicable policies.

a. Suspending Care Coordination Program Payments: Program payments may be suspended under the following circumstances:

   i. If OneCare determines that a Participant, Preferred Provider or Collaborator may not be complying with program requirements, OneCare's Chief Medical Officer (CMO) or his/her designee will investigate the issue(s) in his/her reasonable discretion which may include interviews, access to documents and review of documents related to the Network member's care coordination activities or other fact finding. The CMO will prepare a summary of findings that will be submitted to the Population Health Strategy Committee who will recommend action. Decisions of the PHSC will be communicated promptly and may be appealable pursuant to the Participant Appeals Policy. All determination of the PHSC will be in effect during the pendency of any appeal.

b. Stopping Care Coordination Program Payments: Care Coordination Program payments to a Participant, Preferred Provider or Collaborator may be stopped under the following circumstances:

   i. Participant, Preferred Provider or Collaborator is not meeting program requirements for the Care Coordination Program after the suspension process set forth above has been completed,
   ii. Termination of Participant, Preferred Provider or Collaborator 's agreement with OneCare for any reason,
   iii. Participant, Preferred Provider or Collaborator disenrolls as a billing provider with an insurer in an ACO Program,
   iv. Participant, Preferred Provider or Collaborator becomes ineligible to participate in the Care Coordination Program because the Participant, Preferred Provider or Collaborator dissolves or is acquired by another non-participating Participant, Preferred Provider or Collaborator. OneCare will continue to make Care Coordination Program payments through the month the Participant, Preferred Provider or Collaborator became ineligible and will cease thereafter.
      1. The Participant Appeals process may be used to appeal the payment amount of this proration, however it may not be used to appeal ineligibility based on dissolution of Participant, Preferred Provider or Collaborator practice or acquisition of a practice by a Participant, Preferred Provider or Collaborator within OneCare's network that is not participating in the ACO Program.

**C. Actions/Responsibilities**

Participants, Preferred Providers and Collaborators paid under this model must comply requirements outlined in the ACO Program of Payments all applicable policies, and the OneCare Care Coordination Payment Model Guidance Document approved by the OneCare Population Health Strategy Committee. Each health service area will have access to supports from OneCare's Care Coordination Team in order to assure expectations are met.

**V. References:**

- 06-12 Participant Appeals Policy
- Provider contracts and payer contracts

- Care Coordination Payment Model Guidance Document
- Community Care Coordination Program Policy
- Policy & Procedure Glossary
    - Location: S:\Groups\Managed Care Ops\OneCare Vermont\Policy and Procedures\ Templates & Info\Glossary

**VI. Monitoring & Compliance:** Shared between the Clinical, Analytics, and Finance Departments. The Clinical Department monitors compliance with the Community Care Coordination program. The Analytics Department compiles all data to inform care coordination payments. The Finance Department will monitor and audit the Supplemental Care Coordination payments.

**VII. Related Policies/Procedures:**

- C02-05 Care Coordination & Disease Management Program within an Integrated Care Delivery Model
    - Location: S:\Groups\Managed Care Ops\OneCare Vermont\Policy and Procedures\Procedures\Final PDFs with signature
- C02-06 Care Coordination Training and Responsibilities
    - Location: S:\Groups\Managed Care Ops\OneCare Vermont\Policy and Procedures\Procedures\Final PDFs with signature
- 02-04 OneCare Community Care Coordination Program Policy

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

**Management Approval**:

| | |
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| Director, Value Based Care | Date |
| Director, Care Coordination and Clinical Programs | Date |
| Sr. Director, ACO Finance and Analysis | Date |
| Chief Medical Officer | Date |
| Chief Operating Officer | Date |

**Board of Managers Approval:**

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| Chair, OneCare Board of Managers | Date |

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

## June 16, 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 Policies:

A. 02-04 - Care Coordination Program

B. 04-16 - Advance Community Care Coordination Payments

**OneCare Vermont Accountable Care Organization**
**Board of Managers Resolution**
**June 16, 2020**

## Financial Management Resolution

**BE IT RESOLVED,** by the Board as follows in this "Financial Management Resolution":

That all depository bank(s) or financial institution(s) of OneCare are hereby authorized and directed to pay or otherwise honor or apply, without inquiry and without regard to the application of the proceeds thereof, checks, drafts, notes, bills of exchange, acceptances, undertakings and other instruments or orders for the payment, transfer, or withdrawal of money for whatever purpose and to whomsoever payable, including those drawn to the individual order of a signer, when signed, accepted, or endorsed by the following subject to the terms of this Resolution and the Seventh Amended and Restated Operating Agreements ('the Operating Agreement'):

OneCare Chief Executive Officer
OneCare Chief Financial Officer
OneCare Chief Operating Officer
Senior Director ACO Finance & Payment Reform

**FURTHER RESOLVED:** That any one of the above is hereby authorized, on behalf of OneCare, subject to the terms of this Resolution, the OneCare Disbursement Authority Policy 04-05 as approved by the Board of Managers, and the limitations set forth in Section 6.2 of the Operating Agreement:

1. To borrow money and to obtain credit for OneCare from the depository banks(s) or financial institution(s) on any terms and to execute and deliver notes, drafts, acceptances, instruments of guaranty, agreements, and any other obligations of the Corporation therefore, in form satisfactory to the bank(s) or financial institution(s).

2. To pledge or assign and deliver, as security for money borrowed or credit obtained, stocks, bonds, mutual funds, securities, bills receivable, accounts, mortgages, merchandise, bills of lading or other shipping documents, warehouse receipts, insurance policies, certificates and any other property held by or belonging to OneCare, with full authority to endorse, assign, transfer, or guarantee the same in the name of OneCare.

3. To execute from time to time any and all documents, instruments, agreements, and deeds necessary or appropriate to transfer, sell, assign, or otherwise convey all or a portion of real property and buildings owned by OneCare upon the terms and conditions as he/her or they, in his/her or their sole discretion, may deem necessary or appropriate.

4. To discount any bills receivable or any paper held by OneCare, with full authority to endorse the same in the name of OneCare.

5. To withdraw from the bank(s) or financial institution(s) and give receipt for or to authorize the bank(s) or financial institution(s) to deliver to bearer or to one or more designated persons all or any documents and securities or other property held by it, whether held as collateral security, for safekeeping, or for any other purpose.

6. To sell or to authorize and request the bank(s) or financial institution(s) to purchase or sell, for the account of OneCare, foreign exchange, stocks, bonds, and other securities.

7. To apply for and receive letters of credit and to execute and deliver all necessary or proper documents for that purpose including indemnity agreements, acceptance agreements, trust receipts, guarantees for missing documents, and any of the various instruments which may arise incident to letter of credit transactions and/or acceptance financing.

8. To execute and deliver all instruments and documents required by the bank(s) or financial institution(s) in connection with any of the foregoing matters and to affix the seal of OneCare

9. To authorize other individuals employed by OneCare to as signers on petty cash checking accounts of OneCare, not to exceed $5,000 per account.

**FURTHER RESOLVED:** That pursuant to Section 42 of the Operating Agreement, all financial transactions with a value in excess of $100,000 that are not reflected in Board approved budget items shall require authorization of a supermajority of the Board, as specified therein. Authorization for these transactions shall be reflected in a Resolution of the Board of Managers (a Board approved operating budget shall meet this requirement for a Resolution) and such transactions shall require the signature of two (2) authorized signers. Such authority may be general or confined to specific instances as the Board shall direct.

**FURTHER RESOLVED:** All other Financial Management Resolutions and any authority granted therein, with the exception of the Financial Management Resolution approved by the Board on September 18, 2018 granting specific authority to the OneCare Chief Executive Officer, are hereby revoked.

**FURTHER RESOLVED:** That this instrument be inserted in the corporate minutes book of the Corporation.

This certificate is dated as of June 16, 2020.

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Chair of the Board of Managers

# Board of Managers Policy Summary

## Disbursement Authority

*June 2020*

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

- **04-06 Disbursement Authority**
  - **Description**: Provides guidelines for the appropriate delegation of signature and approval authority for financial transactions.
  - **Key Changes**: Option added for two Vice Presidents or above to approve spending in excess of $1M (in addition to the existing option for approval by one Director and either one Vice President or the Chief Executive Officer).

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| **Policy Number & Title** | 04-06 OneCare Disbursement Authority |
| **Responsible Department/s:** | Finance |
| **Author:** | Tom Borys, Sr. Director Finance and Payment Reform |
| **Date Implemented:** | 09/18/2018 |
| **Date Reviewed/Revised:** | 06/01/2020 |
| **Next Review Date:** | 04/01/2021 |

**Purpose:**

The purpose of this policy is to provide guidelines for the appropriate delegation of signature and approval authority for financial transactions at OneCare Vermont Accountable Care Organization, LLC (OneCare Vermont). A sound internal control environment requires that only authorized individuals may approve financial transactions. OneCare Vermont relies on these internal control measures to ensure the appropriate procedures and levels of approval for all purchasing and payment methods are followed to ensure:

- Only legitimate and appropriate transactions are executed and recorded;
- Transactions are executed as intended, and in accordance with OneCare Vermont policy and relevant financial, legal and contractual requirements; and
- Errors are detected prior to execution.

**Policy Statement:**

Sound fiscal responsibility for OneCare Vermont requires that the person with the appropriate level of responsibility and accountability authorize the commitment of and approve payment from OneCare Vermont funds. This policy is intended to ensure compliance with State and federal regulations, provide effective financial management and create a flow of information that supports analysis, forecasting and planning.

**Applicability:**

This policy applies to all forms of payment, including ACH and wire transfers, or any type of payment made by any electronic media.

**Procedure for Approval:**

Board of Manager Approved Operational Expenses: OneCare Vermont creates an operating budget for each fiscal year that is approved by the Board of Managers. Levels of authority for budgeted expenditures within the Board approved budget are as follows:

- Spending up to $100,000 requires the approval of one (1) Director

- Spending greater than 100,000, but less than $1M requires the approval of two (2) Directors or one (1) Director and **either** one (1) Vice President or the Chief Executive Officer
- Spending in excess of $1M requires **either:**
    - The approval of one (1) Director **and** either one (1) Vice President or the Chief Executive Officer
    - The approval of two (2) Vice Presidents or above

Unbudgeted Operational Expenses: Should operational needs require the disbursement of unbudgeted expenditures, the following levels of authority apply:

- Spending up to $50,000 requires the approval of the Senior Director, ACO Finance & Payment Reform
- Spending greater than $50,000 but less than $100,000 requires the approval of either one (1) Vice President or the Chief Executive Officer
- Spending of greater than $100,000 on unbudgeted expenses is not permitted without the approval of the Board of Managers

**Related Policies/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 Vermont Board of Managers Date

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

## June 16, 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 Policies:

A. 04-06 - Disbursement Authority