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

October 19, 2021
4:30 p.m. – 5:40 p.m.
Zoom Meeting

Time	Agenda Item	Presenter
4:30 p.m.	Call to Order and Board Announcements	John Brumsted, MD
4:31 p.m.	Welcome Board Managers, Invited Guests, and Members of the Public	John Brumsted, MD
4:33 p.m.	Consent Agenda Items* *Vote to Approve Consent Agenda Items*	John Brumsted, MD
4:35 p.m.	Governance* *Vote to Approve Resolution Appointing Representatives to the Board of Managers*	John Brumsted, MD
4:40 p.m.	CEO Strategy Discussion*	Vicki Loner
4:55 p.m.	Budget Submission Communications*	Amy Bodette
5:05 p.m.	Annual Compliance Training*	Greg Daniels
5:25 p.m.	Public Comment Move to Executive Session* *Vote to Approve Resolution to Move to Executive Session*	John Brumsted, MD
5:35 p.m.	Votes 1. Approve Executive Session Consent Agenda Items	John Brumsted, MD
5:40 p.m.	Adjourn	John Brumsted, MD

*Denotes Attachments

Attachments:

1. Consent Agenda Items
    a. Draft OneCare Public Session Minutes September 21, 2021
    b. Board Committee Reports October 2021
    c. Financial Statement Package August 2021
    d. Public Affairs Report October 2021
2. Governance

    a. Resolution Appointing Representatives to the Board of Managers
3. CEO Strategy Discussion
    a. Key Considerations for Leaders before creating an internal EDI committee by Nyacko Pearl Perry
    b. Deloitte Insights: The Inclusion Imperative for Boards – Redefining board responsibilities to support organizational inclusion *Link to Article*
4. OneCare 2022 Budget Submission Fast Facts
5. Annual Compliance Training 2021 Board of Managers Presentation
6. Resolution to Move to Executive Session

OneCare Vermont Accountable Care Organization, LLC
Board of Managers Meeting
September 21, 2021

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 September 21, 2021.

I. Call to Order and Board Announcements

Chair John Brumsted, MD called the meeting to order at 4:31 p.m.

II. Welcome Board Managers, Invited Guests, and Members of the Public

Chair Brumsted welcomed members of the public in attendance.

III. Consent Agenda Items

As part of the distributed pre-meeting materials, the Board received Consent Agenda Items including: (1) Draft of OneCare Public Session Minutes August 17, 2021; (2) Board Committee Reports September 2021; (3) Financial Statement Package July 2021; and (4) Public Affairs Report September 2021. An opportunity for discussion of any of these items was offered.

A Motion to Approve the Consent Agenda Items was made by S. LeBlanc, seconded by C. Kohaut and approved by a majority vote of the Managers present. S. Lowell was not present for the vote.

IV. CEO Strategy Discussion

Vicki Loner, Chief Executive Officer, announced that OneCare has hired Dr. Carrie Wulfman, MD, to be OneCare's Chief Medical Officer beginning October 1, 2021 and described Dr. Wulfman's previous work with the ACO and her qualifications. Ms. Loner shared findings of the independent study conducted by NORC at the University of Chicago which demonstrated positive results for Program Years 2018 and 2019 of the All-Payer Model. The report received positive national and local media coverage. An opportunity for discussion was offered.

V. 2022 Network Composition

Sara Barry, Chief Operating Officer, described network composition and program expansion for the Program Year (PY) 2022 ACO Network. 21 organizations have expanded their participation in OneCare payer programs, primarily in commercial programs. Two independent practices are rejoining the ACO after declining to participate in PY 2021. The Board discussed that the ACO is a coalition of willing participants and that increased Network participation for PY 2022 demonstrates that providers want to be in the Network which is very positive. The Board asked to share the increased participation levels with local legislators or members of the public.

VI. Public Comment

Member of the public Alex Bambery made public comment asking for support in managing some complex problems she has been experiencing. The Board offered for Ms. Barry and incoming CMO Dr. Carrie Wulfman to provide her support in connecting to available services.

VII. Move to Executive Session

A Motion to move to Approve the Resolution to Move to Executive Session was made by Dr. J. Perras, seconded by J. Sayles and was approved by a unanimous vote.

VIII. Votes

1. Executive Session Consent Agenda Items – Approved by Majority.
2. Resolution Adopting 2022 Network Participation Variance Requests – Approved by Majority. Dr. J. Brumsted, Dr. B. Pierratini, and R. Vincent recused themselves from the vote.
3. Resolution Adopting CPR Program Participation – Approved by Majority.
4. Resolution Adopting 2022 Budget and Submission to GMCB – Approved by Supermajority.
5. Resolution Approving 9th Amended and Restated Operating Agreement – Approved by Supermajority.

IX. Adjournment

Upon a Motion made, seconded, and approved by a unanimous vote, the meeting adjourned at 6:42 p.m.

Attendance:

OneCare Board Members

☒ Dan Bennett	☒ Coleen Kohaut	☐ Toby Sadkin, MD
☒ Bob Bick	☐ Sally Kraft, MD	☐ John Saroyan, MD
☒ John Brumsted, MD	☒ Steve LeBlanc	☒ John Sayles
☒ Michael Costa	☒ Sierra Lowell	☒ Cynthia Turner
☒ Betsy Davis	☒ Stuart May	☒ Adriane Trout, MD
☒ Tom Dee	☒ Joseph Perras, MD	☒ Rick Vincent
☒ Claudio Fort	☒ Robert Pierattini, MD	
☐ Steve Gordon		

S. Lowell joined the meeting at 4:42 p.m.

OneCare Risk Strategy Committee

☒ Dean French, MD	☒ Brian Nall	☒ Shawn Tester
☐ Steve Leffler, MD		

D. French joined the meeting at 4:35 p.m.

OneCare Leadership and Staff

☒ Vicki Loner	☒ Tom Borys	☒ Linda Cohen, Esq.
☒ Sara Barry	☒ Amy Bodette	☒ Lucie Garand
☐ Greg Daniels, Esq.	☒ Derek Raynes	☒ Ginger Irish
☒ Josiah Mueller	☒ Lindsay Morse	

Invited Guests

☒ Eric Miller, Esq.	☒ John Kacavas, Esq.

OneCare Board of Managers Committee Reports
October 2021

Executive Committee (meets monthly)
The committee did not meet in October. The committee conducted business electronically to nominate board managers. The committee is next scheduled to meet on November 2, 2021.

Finance Committee (meets monthly)
At its October 13 meeting, committee members reviewed and discussed payer negotiations for program year 2022 with Medicaid, BCBSVT and MVP. The committee reviewed and discussed the financial 2021 Performance Review and discussed the upcoming 2022 budget presentation to the Green Mountain Care Board. The committee meets next on November 9, 2021.

Population Health Strategy Committee (meets monthly)
Due to Indigenous Peoples Day on October 11 this committee was rescheduled to meet on October 27, 2021.

Patient & Family Advisory Committee (meets monthly)
At its September 28 meeting, committee members discussed current work conducted by the Board of Managers and recent public affairs and communications efforts. The committee reviewed videos about OneCare Vermont and shared feedback, as well as the recent addition of "OneCare for better care," a tagline committee members developed in partnership with OneCare. Committee members gave feedback regarding the Care Coordination Program Redesign. The committee then engaged in a thoughtful discussion regarding their thoughts and questions they had from the Town Hall Session about the All-Payer Model that was held by the Vermont Agency of Human Services on September 23. The Patient and Family Advisory Committee meets next on October 26, 2021.

Clinical & Quality Advisory Committee (meets bi-monthly)
At its October 14 meeting, Dr. Carrie Wulfman provided a welcome and introductory words. OneCare presented information regarding health equity to the committee and the committee discussed health equity interventions. The committee reviewed and discussed care coordination and had an open discussion about future committee topics and meeting logistics. This committee meets next on December 9, 2021.

Pediatric Subcommittee (meets bi-monthly)
The next committee meeting is currently being scheduled with date TBD.

Laboratory Subcommittee (meets quarterly)
The next committee meeting is currently being scheduled with date TBD.

Prevention and Health Promotion Advisory Committee (meets quarterly)
The committee is next scheduled to meet on November 2, 2021.

Audit Committee (meets quarterly)
The committee is next scheduled to meet on November 4, 2021.

OneCare Vermont
Statement of Financial Position

For the Periods Ended	**8/31/2021**	**7/31/2021**	**Variance**
ASSETS			
Current assets:			
Unrestricted Cash	12,197,942	13,383,447	(1,185,505)
OCV Reserve Funding	4,000,000	4,000,000	-
Advance Funding-Medicaid	12,112,064	12,123,943	(11,879)
Oustanding VBIF	5,256,780	4,884,741	372,039
Deferred par fees	2,572,101	2,572,101	-
Undistributed Grant Funding	-	13,512	(13,512)
Undistributed Medicare - 2019			-
Total Cash	36,138,887	36,977,743	(838,856)
Network Receivable	120,214	145,002	(24,788)
Network Receivable-Settlement	24,614,340	31,841,499	(7,227,159)
Other Receivable	763,580	767,318	(3,738)
Other Receivable-Settlement	24,647,158	17,802,361	6,844,796
Prepaid Expense	1,393,613	2,249,336	(855,723)
Property and equipment (net)	34,212	34,802	(590)
TOTAL ASSETS	**87,712,003**	**89,818,061**	**(2,106,059)**
LIABILITIES AND NET ASSETS			
Current liabilities:			
Accrued Expenses - Accounts payable	452,664	564,606	(111,942)
Accrued Expenses Deliverables	19,300	36,668	(17,368)
Accrued PHM Expenses (payors)	1,067,879	1,057,271	10,609
Accrued Expenses	1,539,844	1,658,545	(118,702)
Accrued Expenses -Settlement	38,053,777	39,605,663	(1,551,886)
Network Payable	10,097,799	11,180,929	(1,083,130)
Network Payable-settlement	11,811,487	9,775,913	2,035,574
Notes Payable	-	-	-
CTO Liability	491,984	515,262	(23,278)
Payroll accrual	141,489	97,089	44,400
Deferred Income	17,561,272	18,340,759	(779,487)
Deferred Grant Income	-	13,203	(13,203)
Due to Related Parties - UVMMC	3,307,202	3,339,155	(31,953)
Due to Related Parties - DHH	-	-	-
Total Liabilities	**83,004,854**	**84,526,518**	**(1,521,664)**
Net assets:			
Unrestricted - UVMMC	2,843,214	2,843,214	-
Unrestricted - DHH	2,843,214	2,843,214	-
Current Year Profit to Date	(979,278)	(394,884)	(584,395)
Total net assets	**4,707,149**	**5,291,544**	**(584,395)**
TOTAL LIABILITIES AND NET ASSETS	**87,712,003**	**89,818,062**	**(2,106,059)**

OneCare Vermont

Surplus & Loss Statement: YTD AUGUST 2021

	Annual Budget	YTDBudget	YTD Prior Month	August Actual	Monthly Budget	Month Variance	YTD Actual	YTD Budget	YTD Variance
Fixed Prospective Payments Funding	407,254,322	271,502,881	240,650,195	34,182,741	33,937,860	244,881	274,832,936	271,502,881	3,330,055
Payor Contracts Funding	11,923,620	7,949,080	6,571,208	918,736	993,635	(74,899)	7,489,945	7,949,080	(459,136)
DSR Funding	2,900,000	1,933,333	-	-	241,667	(241,667)	-	1,933,333	(1,933,333)
Other Funding	10,472,186	6,981,457	5,184,340	832,007	872,682	(40,676)	6,016,347	6,981,457	(965,110)
Settlement Income	-	-	-	5,300,310	-	5,300,310	5,300,310	-	5,300,310
Deferred Participation Fees (prior year)	2,288,937	1,525,958	162,664	-	190,745	(190,745)	162,664	1,525,958	(1,363,294)
Participation Fees	15,056,520	10,037,680	8,782,970	1,254,710	1,254,710	(0)	10,037,680	10,037,680	0
Total Funding	**449,895,585**	**299,930,390**	**261,351,377**	**42,488,504**	**37,491,299**	**4,997,206**	**303,839,882**	**299,930,390**	**3,909,492**
Fixed Payments	405,100,213	270,066,808	238,668,243	34,186,991	33,758,351	(428,640)	272,855,234	270,066,808	(2,788,426)
Populations Health Mgmt Payment	8,489,946	5,659,964	5,270,038	759,733	707,496	(52,237)	6,029,771	5,659,964	(369,806)
Complex Care Coordination Program	6,459,185	4,306,123	3,186,370	439,990	538,265	98,275	3,626,360	4,306,123	679,763
Value-Based Incentive Fund	2,235,990	1,490,660	1,304,327	186,332	186,332	0	1,490,660	1,490,660	0
Blueprint Funding	8,767,133	5,844,755	5,114,161	730,594	730,594	(0)	5,844,756	5,844,755	(0)
Other PHM Programs	2,937,460	1,958,307	871,040	112,654	244,788	132,135	983,693	1,958,307	974,613
Settlement Expense	-	-	(0)	5,289,225	-	(5,289,225)	5,289,225	-	(5,289,225)
PHM Expenses	**433,989,926**	**289,326,618**	**254,414,178**	**41,705,520**	**36,165,827**	**(5,539,693)**	**296,119,698**	**289,326,618**	**(6,793,081)**
							-	-	-
Salaries and Fringe	9,646,062	6,430,708	4,602,983	859,755	803,838	(55,916)	5,462,738	6,430,708	967,970
Purchased Services	1,180,148	786,765	439,263	160,688	98,346	(62,342)	599,951	786,765	186,814
Contract & Maintenance	263,000	175,333	9,347	169,520	21,917	(147,604)	178,868	175,333	(3,534)
Lease & Rental	427,522	285,015	210,677	28,640	35,627	6,987	239,317	285,015	45,697
Utilities	44,050	29,367	14,638	3,747	3,671	(76)	18,385	29,367	10,982
Other Expenses	4,344,877	2,896,584	2,055,173	145,030	362,073	217,043	2,200,203	2,896,584	696,381
Operating Expenses	**15,905,658**	**10,603,772**	**7,332,083**	**1,367,379**	**1,325,472**	**(41,908)**	**8,699,462**	**10,603,772**	**1,904,310**
Total Expenses	**449,895,585**	**299,930,390**	**261,746,261**	**43,072,899**	**37,491,299**	**(5,581,600)**	**304,819,160**	**299,930,390**	**(4,888,770)**
Net Income (Loss)	**(0)**	**(0)**	**(394,884)**	**(584,395)**	**(0)**	**(584,395)**	**(979,278)**	**(0)**	**(979,278)**

OneCare Vermont

Public Affairs Report | October 2021

Media Coverage

Vicki Loner: Value-Based Care Better Serves our Providers and Community

October 12, 2021, VTDigger
October 8, 2021, Caledonian Record

This is an opinion piece from Vicki Loner to highlight our budget submission to the GMCB and how it "balances the benefit of investment in our system's transition to value-based care with the costs to our participating hospitals, recognizing the economic hardship this pandemic has brought to our provider partners." Loner also notes that the budget reflects our principles and continued efforts to realize a value-based health care system for our state.

OneCare Vermont submits 2021 budget, reports increased participation

October 2, 2021, Vermont Business Magazine

This coverage provides highlights of OneCare's 2022 budget and includes quotes of support from member providers. Highlights listed in the coverage:

- An additional 28,000 Vermonters will receive care from providers participating in OneCare and this new participation will contribute to meeting the scale targets.
- There is increased and more in-depth hospital and provider participation in OneCare payer programs from last year.
- Primary care providers in OneCare are projected to receive over $18 million dollars in investments to primary care, a focus of Vermont's All-Payer ACO model, in addition to payments received for care delivery. Of the total OneCare budget, 1.1% is designated for operating costs.

Jon Asselin of Primary Care Health Partners is one of the providers quoted:

"We are appreciative to have the opportunity to continue our participation in the Comprehensive Payment Reform program in 2021," said Asselin. "This program has provided relief to the challenges facing our independent primary care practices since the program's formation in 2018. This program has enabled us to sustain and expand the delivery of primary care services throughout Vermont. Of special note is how the CPR's fixed payments limited our revenue losses when COVID-19 hit. Had we not been in CPR and relied solely on fee-for-service, we would have seen greater losses during the state of emergency given the reduction in the number of in-person office visits. The fixed payments helped provide a safety net during these extraordinarily difficult times."

Vermont Edition

September 29, 2021, VPR

Vicki Loner, OneCare CEO, was on the first 15 minutes of Vermont Edition to discuss the news of UVMHN becoming the sole parent organization. Many of the questions were driven by the VTDigger reporting—they asked if the governance change was a conflict of interest for UVMHN; they called out transparency issues around salaries; suggested that OneCare made the change to 501(c)(3) because of pressure from journalists and the state auditor; questioned if OneCare would have less of a focus on care in the Upper Valley; and the last question was about health equity and whether or not the board is reflective of Vermont's growing racial and ethnic diversity. Loner was able to offer some background on OneCare and what we are all about with a focus on prevention, how our governance board is required to be structured to include participating providers; address the transparency issue and talked about our board make-up and how no one representative can sway the vote; assured listeners that OneCare is still just as focused on the Upper Valley; and talked about all the work being done at the board level to evaluate and increase diversity.

Dr. Levine was on for the rest of the VT Edition hour and he was asked his thoughts on the governance change. He did a nice job pivoting to what he supports about OneCare and how its ultimate goal of addressing the health of the population is aligned with the goals of the Vermont Department of Health.

UVM Health Network to become sole parent company of statewide all-payer ACO

September 27, 2021, Becker Hospital Review

This is coverage of the governance change at OneCare where UVM Health Network will now be the sole parent organization. This is accurate coverage and used quotes from Tom Dee, of Southern Vermont Health Care, and Steve LeBlanc, of Dartmouth-Hitchcock Health, from the joint media release on the topic.

UVM Health Network to become sole operator of OneCare

September 24, 2021, WCAX

This is coverage of the governance change at OneCare where UVM Health Network will now be the sole parent organization. This is accurate coverage that hits on the key points that this change won't make a difference for patients and that it will streamline internal operations, bringing sustainability for the organization and its mission in the long-term.

OneCare to become part of UVM Health Network

September 24, 2021, VTDigger

This is coverage of the governance change at OneCare where UVM Health Network will now be the sole parent organization. The coverage gets several points wrong, including claiming that OneCare's data services and accounting will be absorbed by UVMHN; that OneCare became a 501(c)(3) because of pressure from VTDigger's reporting on lack of salary transparency, among other pressures; and that the UVMHN is paying itself through the ACO. To aim to correct the misinformation in this piece and some of the other reporting inspired by it, these key takeaways were posted on our blog post ahead of our media release on the governance change:

- Dartmouth Hitchock-Health (DH-H) and University of Vermont Health Network (UVMHN) founded OneCare in 2012, with UVMHN providing operational support and DH-H providing accountable care organization (ACO) expertise to get OneCare up and running. OneCare has evolved and become an established ACO for the state of Vermont and so it makes sense for DH-H to step away as a parent organization. However, D-HH will continue to fully participate in OneCare programs as a provider member and will have a seat on the OneCare board of managers.
- UVMHN will now be the sole parent organization of OneCare Vermont, continuing to provide operational support as they always have—like sharing human resources, information technology, and payroll services. To be clear, UVMHN will not absorb OneCare's data services nor our accounting. OneCare and UVMHN will, however, look for other opportunities to share positions and services that will create more efficiencies and be mutually beneficial in the shared mission to expand value-based care, meaning more dollars can go directly to health care rather than business operations.
- OneCare will remain an independent federal 501(c)(3) with its own governance structure and board of managers. The decision to move to a sole parent organization was made by OneCare's board of managers, which represents providers and consumers, and is a natural outgrowth of OneCare's strategic planning process. Along with this governance change, OneCare's strategic plan gives us the stability and focus to continue our work supporting providers as they transition to value-based care.
- UVMHN's position as a sole parent in no way causes a conflict of interest or reduces transparency in OneCare's work. All decisions about how health care dollars are distributed are made by the OneCare Board of Managers, which represents a broad cross section of providers and consumers, rather than by the parent organization. Changes to OneCare policies – including those that determine how these dollars are distributed—must be by majority (11 out of 21 board members) or supermajority (14 out of 21 board members). UVMHN has four seats on the Board. No single provider – even the University of Vermont Health Network—has the ability to exercise outsized or improper influence over its role in the model. And OneCare continues to be regulated by the Green Mountain Care Board, which closely oversees our work.

VTDigger Sponsored Spotlight: Engaging with Data & Analytics to Transform Health Care and Improve the Health of the Population

September 18, 2021, VTDigger

This is a paid sponsored spotlight article OneCare placed in VT Digger and authored by OneCare's public affairs team. The write-up is based on the videos put together to give an overview of OneCare's data & analytics core capability. The article has the video embedded and includes quotes from the video interview with Eilidh Pederson, COO of Brattleboro Memorial Hospital. Additional ads driving to the data & analytics videos were placed in three editions of the Daily Digger in the week of Sept 19th, and on the VTDigger website from mid-September to mid-October.

OneCare Vermont Announces Dr. Carrie Wulfman of Ripton as New Chief Medical Officer

September 17, 2021, VTDigger

OneCare's press release announcing Dr. Carrie Wulfman as new CMO at OneCare. The piece also links to a Q&A on our blog. Check it out to learn more about Dr. Wulfman!

Government Relations

State Legislative Update

On September 23, the Vermont Agency of Human Services (AHS) held a virtual town hall meeting to discuss plans for seeking a one-year extension of the All-Payer ACO Model Agreement which is effective January 1, 2017 through December 31, 2022. The State is not seeking to add any additional services such as Medicaid home- and community-based services, mental health services, and substance use disorder services to the All-Payer Financial Target Services which are subject to growth targets. Attendees were given the opportunity to provide public comment after the overview of the proposal. Additional forums about improving alignment between the delivery and financing of these services with services provided through the ACO will be discussed.

On September 29, the Task Force on Affordable Accessible Healthcare met. The task force has retained Health Systems Transformation, a healthcare consulting firm to help the task force with their work. They heard from 3 consultants: Joshua Slen, Julie Trottier and Tim Hill.

The consultants reviewed their Principles of Affordability and Principles for Accessible Health Care which were discussed by the task force. The task force would like to start to look at more specific information such as whether other states that have put caps on hospital growth, insurance rate growth, and medical inflation, workforce issues and the corresponding impact and stress on the health care system. The task force plans to look more closely at accessibility with continued focus on telehealth and loan repayment programs to help with workforce issues. The consultants also presented their list of new options for cost containment which intentionally excludes programs already in progress including the All Payer ACO Model, Blueprint, and VITL, among others. The list suggests looking at new federal possibilities with Biden Administration as well as continued building off the Blueprint and other regulatory suggestions the task force could consider.

The task force will meet three more times before the 2022 Legislative Session and will bring proposals before key legislative committees in January. Meetings are scheduled for 10/28, 11/22, and 12/15.

Green Mountain Care Board

The Green Mountain Care Board (GMCB) has not met since September 15 when they were finalizing Hospital Budget decisions. The next meeting of the GMCB is on October 13 during which the committee will review the GMCB Staff's proposed 2022-2023 analytics plans as well as 2022 Draft Budget Guidance and Reporting Requirements for Medicare Only, Non-Certified Accountable Care Organizations.

Outreach and Advocacy

OneCare's Primary Prevention Program's Walkability Workshops

Walkability is important all year around, but it is particularly timely now as students return to school. Walking to school is a great way for children to get the recommended 60-minutes of physical activity per day. This activity is an important step for ensuring children stay healthy. Unfortunately, the National Center for Safe Routes to School and the US Department of Transportation show a steady decline in the number of students who walk to school since 1969. The good news is that this trend can be reduced. This past spring, OneCare Vermont's RiseVT program hosted national public health, planning, and transportation consultant, Mark Fenton, for a two-part workshop to improve walkability in Vermont. Mark Fenton emphasized that organizations can begin improving their communities immediately and affordably before investing in expensive infrastructure. Even simple one-time events such as a Walk-To-School Day can increase the number of students walking to school for weeks after the initial event.

Social Media Highlight: World Mental Health Day

Every October 10, we acknowledge World Mental Health Day - a global effort dedicated to raising awareness of the importance of mental health and advocating against the stigma associated with getting mental health care. OneCare supports facilitating access to mental health services and incorporating it into a holistic approach to care as a key strategy in improving quality of care and health outcomes in Vermont. We support our health care providers in implementing best practices to get Vermonters the mental care they need.

Mental health is important for persons of all ages and groups, especially with the additional stressors and challenges brought on by the COVID-19 pandemic. A report by UNICEF estimates that more "than one in seven adolescents aged 10–19 is estimated to live

with a diagnosed mental disorder globally" - https://www.unicef.org/press-releases/impact-covid-19-poor-mental-health-children-and-young-people-tip-iceberg. In Vermont, suicide is the 8th leading cause of death in the state: https://www.healthvermont.gov/sites/default/files/documents/pdf/HSVR_Injury_Suicide_Databrief_2021.pdf.

The Howard Center of Vermont is acknowledging World Mental Health Day with a special speaker series all through the month of October to discuss mental health, resilience, and compassion fatigue – we encourage you to sign up: https://howardcenter.org/category/special-events.

National Suicide Prevention Lifeline
1-800-273-8255
Vermonters: Crisis Text Line
Text VT to 741741
Free, confidential help is available 24/7.

Care Navigator User Group

October 22, 9:30 - 10:30 a.m.

At OneCare's bimonthly Care Navigator user group call, you will have the opportunity to identify community needs that OneCare can support you with and can participate in active discussion regarding roll-out suggestions, tips from the field, issues, and questions. Attendees will also receive updates on new features and system enhancements, hear news about what may be coming up in payment reform trainings, and learn about other healthcare happenings. This meeting is open to all Care Navigator live environment users to create a community around the tool and support collective learning. Each month we will have a different focus and unique information. Slides and information will be sent following the call. Click here to join the Care Navigator user group call.

Follow Us

You can keep up with OneCare on our blog, LinkedIn, and Twitter (@OnecareVermont) and with OneCare's primary prevention program RiseVT on Facebook, Instagram, and YouTube. We would greatly appreciate it if you like and share our content to help spread awareness.

Questions? Contact OneCare Public Affairs using the Contact Us form on our website or email us at public@onecarevt.org.

OneCare Vermont

OneCare Vermont Accountable Care Organization
Board of Managers Resolution Appointing Representatives to the Board of Managers
October 19, 2021

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 the recommendations of the Nominating Committee and the qualifications of the candidates, hereby approves the appointment of the following Managers:

A. Manager representing an Academic Medical Center located in New Hampshire and serving Vermonters for a three-year term beginning on October 19, 2021 and ending on September 30, 2024; and

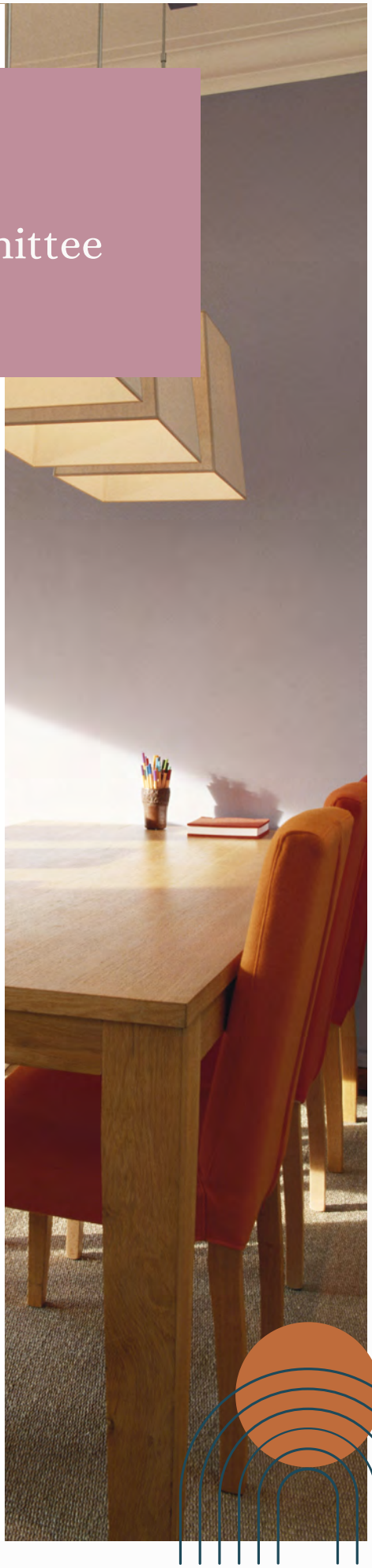
B. Medicaid Beneficiary for a three-year renewal term beginning on November 1, 2021 and ending on October 31, 2024; and

C. Medicare Beneficiary for a three-year renewal term beginning on December 1, 2021 and ending on November 30, 2024.

SEPTEMBER 2021

Key Considerations for Leaders before creating an internal EDI committee

by Nyacko Pearl Perry



When done well, Equity Diversity Inclusion (EDI) Committees are a powerful way to engage employees and build momentum for lasting change in your organization. When done poorly, EDI Committees can have the opposite effect and negatively impact committee members and exacerbate existing inequities. Below are seven key considerations for organizational leaders as you develop your internal EDI Committees to minimize harm and maximum impact:

Interrogate your "Why"

EDI committees are established to address key EDI concerns within an organization. Aspects of EDI work may be uncomfortable for leaders. It is natural to feel anxious and even vulnerable when learning about the inequities that exist in your organization and reckoning with the fact you may have unknowingly perpetuated some of them. Thus, it is critical to ground yourself in your "why'' so that you can stay focused on supporting the actions of the EDI committee even if you may feel anxiety in the process. Here's how to do this:

- Examine what is motivating you to institute an EDI committee.
- Ensure you are not outsourcing the responsibility of diversity, equity, inclusion to a committee as an act of avoidance instead of holding it as a leadership team.
- Think about how you will manage yourself when you become anxious or uncomfortable about the process.
- Reflect on what you are willing to give to see the effort succeed.
- Get clear about your motivation so that you do not unintentionally obstruct the committee's efforts.

Establish the Committee's purpose

Lack of clarity around the committee's purpose, goals, and outcome impedes your ability to achieve real impact. Committees without clear goals and purpose often experience false starts, overwhelm, frustration, and a lack of accomplishment. Defining the purpose allows you to track and measure your impact around the EDI efforts. Here's how to do this:

- Clarify what this group is tasked to do. Examples of committee tasks include: implementing a retreat, measuring the current state of EDI, selecting an EDI consulting firm.
- Work with committee members to clearly define what the goal and potential outcomes are for the committee.

Provide a Sponsor with institutional power

Typically, a sponsor is a senior leader or member of the C-suite. The goal of the sponsor is to advocate on behalf of the committee, not to dictate the tasks and goals of the committee. This may include acting as an advisor upon the request of the group or establishing a budget for activities. A sponsor should not be an active member of the group but act as an advocate to empower the group and the EDI effort overall.

Consider the membership

Many EDI committee members come from various levels of the organization and may have a variety of identities and lived experiences. Who are the members of the committee, what are their organizational roles and how were they selected? It is important that the committee itself has formal authority. Be sure to ensure that the members hold institutional power as well to influence change and make things happen. Here is how to do this:

- Consider what power dynamics may exist within the committee.
- Be intentional about how the committee comes together, who the members are, and what it means for them to participate in an EDI committee.

Lack of clarity around the committee's purpose, goals, and outcome impedes your ability to achieve real impact.

Set and clarify boundaries

The potential committee may comprise members from various levels of the organization and so it is very important that it is clear what leadership authorizes the group to do and not do. For example, collecting information from employees might be a task taken up by a committee in order to support an EDI initiative. This means that the committee might be privy to information and responsible for maintaining confidentiality. Committee members may even be required to withhold certain details from the leadership of the organization to maintain anonymity and support the overarching goals of the EDI effort. Without defining the boundaries of the group's responsibilities, unnecessary harm can be caused because members may unintentionally cross lines that were not clearly defined. They may fear repercussions for overstepping. The best way to prevent this is to set clear boundaries from the very beginning.

Consider the structure and timeframe

Is this a committee with a specific task and once it is completed, the committee dissolves? Is this meant to be a prolonged effort? Set expectations by being clear about the duration of the committee. Here is how to do this:

- Allow the committee to establish its meeting frequency and goals with a clear understanding of how long the committee will exist.
- Encourage the committee to establish its own structure. Is this a flat committee or do certain members of specific responsibilities and roles? *There is no one right way to do this but consider the earlier item around the committee members and any power dynamics that may exist.

Compensate for the labor

The work the committee does will greatly benefit the organization and is likely to be mentally and emotionally draining for its members. Accommodating the additional work and labor may require adjusting schedules for hourly employees and considering how you will compensate for any additional time that is expected on top of their full-time duties. Other benefits could include increased opportunities for promotion and more exposure to leadership. Consider how much time and labor is expected for committee work. Here is how to do this:

- Consider how this can also tie in to their job performance review process.
- Clearly communicate to the managers of committee members about these agreements as well.

Lastly, express your gratitude to the committee frequently so they know their effort and commitment is valued by you and the organization!

Special thank you to Tip Fallon, Stephen Graves, Carol Hamilton and Maya Towsend for reviewing this piece!

To get additional support with your committee and to learn more about Nyacko, visit: nyackoperry.com

2022 Budget: Fast Facts

Supporting Providers Participating in Value-Based Care

This budget continues to support the provider network through the ongoing public health emergency and balances expenses with the investments in value-based care transformation.

OneCare is investing in health care reform—and showing results.

A recent evaluation* by the (NORC) – a nonpartisan, independent evaluator – found the Vermont All-Payer Accountable Care Organization Model (or APM) achieved **statistically significant Medicare gross spending reductions** at the ACO and state levels and **statistically significant declines in acute care stays** at the ACO and state levels.

OneCare is committed to submitting a balanced budget to the GMCB each year despite financial challenges in 2022, including:

- State funding to support delivery system reform and HIT funding ended (totaling $6.8M in lost revenue – funds critical in supporting the transition to value-based care).
- Providers and OneCare have chosen to keep risk levels low because health care providers and organizations are under pandemic-related stress and uncertainty.
- Hospital participation fees are increasing by $3.6M to $18.7M in 2022 to fund population health management programs. Hospitals across the state continue to invest heavily in health care reform, and Vermont is able to make strides toward value-based care because of these investments.

Investing in Population Health

$29 million in PHM payments

OneCare is investing nearly $29M in population health management across the full continuum of care in 2022 – investments that are made possible through OneCare's programs. These funds wouldn't be available to providers without OneCare and it is important to sustain investments in population health management and preventive care.

OneCare's network is growing

For 2022, attributed lives have grown by nearly 18,000 Vermonters

The network has grown *nearly tenfold* from 29,100 in 2017 to roughly 288,000 in 2022

In 2022, OneCare represents 136 organizations and 5,023 providers

OneCare's Operating Budget:

Total Cost of Care: 1.1%

OneCare's operating budget is 1.1% of total accountability.

This operating rate is very narrow and demonstrates how efficiently OneCare is partnering with providers, as well as increased efficiency over time.

The operating rate was 1.9% in 2018.

93% of care coordination funding was sustained

across all continuum of care partners

$1.33B

Total Accountability for Health Care in 2022

OneCare's accountability for the cost and quality of Vermont's healthcare is increasing 10.8% to $1.33B.

*https://innovation.cms.gov/data-and-reports/2021/vtapm-1st-eval-report-aag

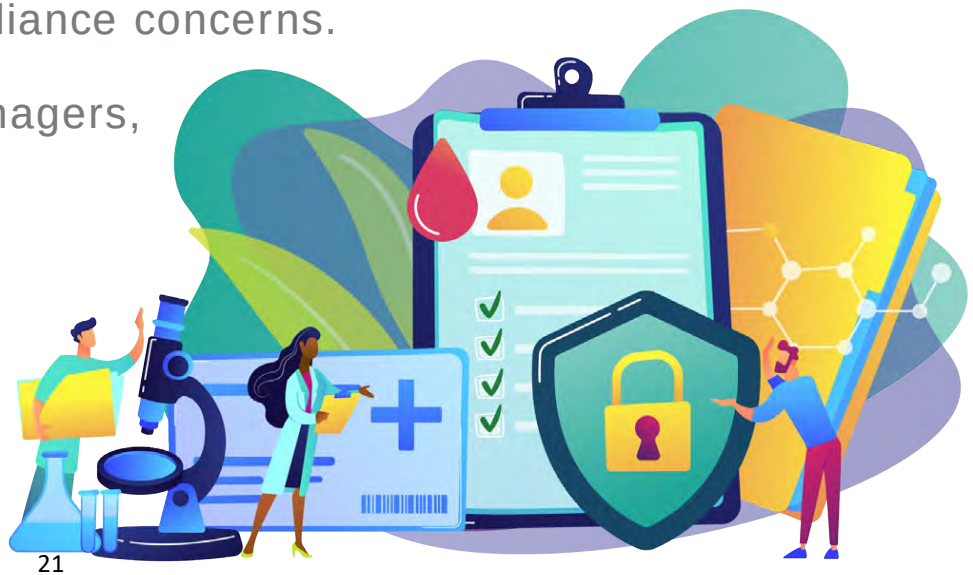
Annual
Compliance Training

Board of Managers
2021

OneCare Vermont
onecarevt.org

Introduction

- Accountable Care Organizations (ACOs) are required to have a Compliance Program and to conduct annual compliance training.
- A Compliance Program helps an ACO abide by all applicable rules and standards, and to discover and correct any practices that do not.
- OneCare Vermont's Compliance Program includes conducting assessments of risk, monitoring processes and programs for fraud, training and education on these topics to prevent compliance issues, and includes a confidential system to report compliance concerns.
- OneCare's Workforce, Board of Managers, and Network have a duty to report violations of applicable laws and regulations, program rules and policies, as well as violations to OneCare's Compliance Program.



The Seven Pillars of an Effective Compliance Program

1. **Standards and Procedures:**
   To ensure compliance with laws, regulations and program rules and prevent and detect fraud, waste and abuse.
2. **High-Level Responsibility:**
   Oversight of the Compliance Program by a designated Chief Compliance Officer and Compliance Committee, with oversight provided by the Board of Managers.
3. **Debarment Screening:**
   Background and exclusion checks for Workforce, Network Entities, Providers, and Vendors conducted as required.
4. **Education and Training:**
   Provided on various Compliance topics, including changes to laws provided to the Board of Managers, Workforce, and Network annually at a minimum.
5. **Monitoring and Auditing:**
   Routinely conduct Risk Assessments, Monitoring Activities and Audits of programs to ensure compliance with laws and prevent fraud, waste and abuse.
6. **Enforcement and Discipline:**
   Suspected violations of law must be reported without fear of retribution or adverse consequences. Willful violations of compliance standards, or healthcare program rules and regulations shall be disciplined.
7. **Response and Prevention:**
   The organization must demonstrate it responds appropriately to reported violations and takes steps to prevent further offenses.

The Five Questions

Should I Check with Compliance? The Five Questions

- Does it require an exchange of anything of value with a physician, patient, or other referral source?
- Does it impact or change the way services are documented, coded, or reimbursed?
- Could it involve any possible conflicts or improper motives - either real or perceived - to be considered?
- Does it require sharing data, ex. PHI, claims data, or other confidential business or financial information, outside of OneCare or its Network?
- Does it require review by Legal? HR? Finance? Etc.?

Four Main Areas of Healthcare Compliance

1. HIPAA Privacy and Security
2. Conflicts of Interest
3. The False Claims Act
4. The Stark Law & The Anti-Kickback Statute

HIPAA Privacy and Security

The **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** protects the privacy and security of health information and provides individuals with certain rights to their health information. The Act is implemented by federal regulations, with the "Big 3" regulations being the **Privacy, Security and the Breach Notification Rules**.

- The **Privacy Rule** sets national standards for when **protected health information (PHI)** may be used and disclosed.
- The **Security Rule** specifies safeguards that **covered entities** and their **business associates** must implement to protect the confidentiality of **electronic protected health information (ePHI).**
- The **Breach Notification Rule** requires covered entities to notify affected individuals, U.S. Dept. of Health & Human Services (HHS) Office for Civil Rights (OCR), and, in some cases, the media of a **breach of unsecured PHI – both ePHI and 'paper' PHI**.

HIPAA Privacy and Security, *continued*

Concepts to Know:

- **Individually Identifiable Health Information** is a subset of health information created by a covered entity that relates to an individuals past, present, or future health information and either identifies the individual, or could be used to identify the individual. E.g. demographic information.
- **Protected Health Information (PHI)** means individually identifiable health information that is transmitted or maintained in electronic or other format by a CE or BA, and specifically excludes individually identifiable health information contained in education and employment records.
- **Personally identifiable information (PII)** is not a term defined by HIPAA, but is used in healthcare settings to refer to health information or data that could be used to identify a person. Under HIPAA, PII or individually identifiable information is treated as PHI.

HIPAA Privacy and Security, *continued*

Concepts to Know, Continued:

- **Covered Entity (CE):** A health plan (ex. health insurance company), health care provider, or health care clearinghouse (ex. claims billing company).
- **Business Associate (BA):** A person or organization that performs functions "for" or "on behalf of" a covered entity.
- **Minimum Necessary Standard:** Disclose, use and make access to only the minimum necessary amount of PHI to accomplish the purpose of disclosure, use and job functions.

- **Role Based Access:** Grant role-based system access to workforce and Network members. Access to systems much be limited to only those people that require access to PHI to carry out their job duties. If a workforce or Network member transfers roles or terminates their employment, access to systems must also be modified or terminated accordingly.

HIPAA Privacy and Security, *continued*

Permitted Uses and Disclosures of PHI:

Written consent not needed if use/disclosure is to/for:

1. **Individual**

2. **Treatment, Payment & Healthcare Operations (TPO)**

   - **Treatment:** coordination of healthcare related services between one or more health care providers.
   - **Payment:** premiums, coverage, reimbursement for healthcare delivered.
   - **Healthcare Operations**: quality assessment & improvement activities including care coordination, audits, fraud & abuse detection and insurance functions, etc.

3. **Public Interest and Benefit:** to protect general public or individual's safety, i.e. PHI disclosed to police related to a crime, organ donation, workers compensation, etc.

OneCare's ACO Activities fall under Healthcare Operations

Conflicts of Interest

Conflict of Interest is a circumstance in which the **interests of a Key Person**, or the Immediate Family of an Key Person, **may conflict, or appear to conflict**, with the interests of OneCare.

A **Key Person** means any Officer, Senior Management Official, or member of a committee or Board of Managers or any other person, Workforce member or position determined by the Board to **exercise substantial influence over the business affairs of OneCare**.

A **Key Person cannot place their personal interests**, interests of Immediate Family members, or the business interests of another organization they may be affiliated with **above the interests of OneCare**.

A Conflict of Interest will **preclude a Key Person from participation** in a decision on the issue(s) associated with the Conflict of Interest when so determined.

Conflicts of Interest, *continued*

All **actual, potential, or perceived conflicts of interests must** be disclosed:

- **Upon hire or appointment** to a Board or Committee of the Board with authority granted to it by the Board;
- **Annually** upon receipt of Conflicts of Interest training; and
- **Interim** when a matter comes before the Board or Committee which may give rise to a conflict of interest.

The CCPO shall review the facts concerning the potential conflict and, if applicable, request that the Interested Person recuse themselves from Committee meetings or discussions at which such interest is discussed.

Examples of Potential Conflicts of Interest:

- Receipt or Giving of Gifts and Gratuities
- Knowledge of Insider information
- Financial Interests (e.g. ownership or investment interest).

The False Claims Act

The **False Claims Act (FCA)** makes it illegal to submit claims to the federal government for payment when the individual or organization "knows", or should know, the claims are false or fraudulent. False claims **may also arise from repeated errors that reflect "deliberate ignorance" or "reckless disregard" of program rules and established processes.**

The FCA allows private individuals to act as "whistleblowers" and bring a lawsuit against any person or entity that has presented false claims for payment by the federal government. **The government may join the suit if they believe the whistleblower's claims have merit.** If the case is won, the whistleblower is entitled to a portion of any monies awarded.

Vermont and New Hampshire have enacted state versions of the FCA that apply to claims for payment by state governments. There are protections under the federal and state FCA for whistleblowers, including retaliation prohibitions.

Penalties under FCAs are severe, and can include fines of millions of dollars as well as exclusion (e.g. debarment) from participation of government healthcare programs.

The False Claims Act, *continued*

For OneCare, False Claims Act liability could potentially arise from:

- Incorrect quality measure reporting, financial, or data submissions
- False certifications of compliance
- Inaccurate program application information
- Failure to return identified overpayments

Does OneCare submit "claims"?

OneCare submits certifications and reports to government payer programs to obtain payment. It also submits large amounts of data to support these certifications and reports. These submissions are similar to provider's fee-for-service claims in which both the federal and state FCAs apply. **Therefore, OneCare's certifications and reports, as well as data submissions, must be supported by auditable records.**

The Stark Law & The Anti-Kickback Statute

These laws are aimed to prevent fraud, waste, and abuse which apply to impermissible relationships as well as illegal "kickbacks" or "inducements" exchanged between providers or gifted to Attributed Lives.

- **Physician Self-Referral Law (aka "The Stark Law):** Prohibits physicians from having a financial interest including ownership, investment and compensation arrangements, with any provider or entity to which they refer patients, payable by Medicare or Medicaid, unless an exemption under the law applies.
    - CMS hold jurisdiction over this civil law; with Civil Monetary Penalties (CMPs) available for pursuit by the HHS OIG's office.
- **The Anti-Kickback Statute (AKS):** Prohibits knowingly taking or providing anything of value to induce patient referrals or otherwise generate business involving services payable by Medicare and Medicaid, unless a safe harbor (aka exemption) applies.
    - HHS OIG holds jurisdiction over this criminal law.

The Stark Law & The Anti-Kickback Statute, *continued*

On January 19, 2021, revised Physician Self-referral law ("Stark Law") exemptions and AKS safe harbors regulations were implemented that contained broad new allowances for "value based arrangements"; defined as arrangements involving at least one "value based activity" for a target population.

The value based arrangement must involve a "value based enterprise," which is two or more participants or providers who collaborate through care coordination, increased efficiencies in delivering care, and improved outcomes for patients; e.g. ACO. Unfortunately, the requirements for the Stark exceptions are not identical to those of the anti-kickback safe harbors.

As a result, two analyses are necessary to determine whether a particular value based arrangement satisfies a Stark Law exemption and a AKS safe harbor. Good intentions alone might not protect the parties to a value based arrangement.

To remain within the Stark Law exception for value based arrangements and the anti-kickback statute safe harbor for in-kind remuneration used for care coordination and care management activities, the value based arrangement must not only be reasonably designed to achieve its goals, it must also work in practice, and the parties must monitor their arrangements.

If problems are identified, the parties must "act quickly to rectify the ineffectiveness of their value based activities" and modify or terminate them.

The Stark Law & The Anti-Kickback Statute, *continued*

Two new AKS Safe Harbors of note:

CMS-Sponsored Model Arrangements and CMS-Sponsored Model Patient Incentives:

AKS safe harbor addition for delivery and payment arrangements, and patient incentives, provided in connection with models under either the CMS Innovation Center or MSSP. This safe harbor does not replace existing fraud and abuse ACO waivers (which remain in effect), but instead should reduce the future need for model-specific waivers.

Under the safe harbor, only CMS-sponsored model arrangements and patient incentives are protected, and they must:

(1) advance one or more goals of the CMS sponsored model; and

(2) have either a direct connection to the patient's health care, or to a different standard (in which case the different standard must be met).

ACO Beneficiary Incentive Program:

By statute, accountable care organizations ("ACOs") participating in certain CMS-approved, two-sided risk models may provide incentive payments to beneficiaries who receive qualifying primary care services. The anti-kickback statute safe harbor follows the statutory exception, and protects incentive payments for beneficiaries assigned to the ACO by CMS.

The Stark Law & The Anti-Kickback Statute, *ACO Waivers*

ACO Waivers permit OneCare to waive certain provisions of the Stark Law, the Anti-Kickback Statute and other fraud, waste and abuse laws to carry out the healthcare activities of an Accountable Care Organization.

ACO Waivers available are for the following:

1. **Pre-Participation Waiver**
2. **Participation Waiver**
3. **Shared Savings Distribution Waiver**
4. **The Physician Self-Referral Law (aka Stark Law) Waiver**
5. **Waiver for Patient Incentives**

Only OneCare, as the ACO, has the authority to invoke the use of ACO Waivers for its programs and activities through approval by its Board of Managers.

Risk Areas for ACOs

ACOs have compliance issues in common with traditional healthcare providers, but they also have compliance risks that are unique to the ACO environment.

OneCare has certain requirements built into our Participation Agreement with CMS that give rise to specific areas of risk, including, but not limited to:

- **Stinting on Care or Overutilization**
- **Beneficiary Outreach and Marketing**
- **Patient Choice**
- **Patient Inducements**

OneCare may be audited in these areas, and could incur sanctions, including mandated corrective action plans and potentially termination from the ACO program.

Risk Area: Stinting on Care or Over-Utilization

Because ACO Programs reward providers with lower expenditures, ACO Providers must ensure that they are not providing reduced care to ACO beneficiaries, to inappropriately reduce costs.

An ACO may not encourage a provider to reduce or limit medically necessary services.

ACO Providers may not over-utilize services provided to non-ACO beneficiaries to make up for revenues not achieved due to cost-saving measures.

Risk Area: Beneficiary Outreach and Marketing

In order to prevent ACOs from seeking to attract or avoid beneficiaries with certain health profiles, an ACO's communication and marketing outreach with Attributed Lives is regulated.

OneCare is required to send a letter to all Attributed Lives notifying them that their provider is participating in the ACO and they have the option to "opt-out".

In some cases the ACO must use specific templates and language as required by program requirements or law, including the opt-out letter noted above.

Educational materials specific to Attributed Lives' participation in the ACO must be submitted to CMS for approval before being distributed.

Risk Area: Patient Choice

Patients assigned to an ACO have full freedom of choice in selecting providers. Attributed Lives may choose providers outside of the ACO with no penalty.

ACO Network providers must honor patient choice and may not restrict referrals to within the ACO.

Risk Area: Inducements to Patients

- OneCare may not offer or provide gifts or other inducements to Attributed Lives to encourage them to receive services from the Network.
- OneCare and its Network may, however, provide items or services related to the Attributed Live medical care that are either preventive in nature or help the beneficiary achieve a clinical goal.
  - For example, a provider may provide an at-home blood-pressure monitor to a patient **who has been instructed to take daily blood-pressure readings related to their care.**
- **OneCare is required to maintain the records for each in-kind item or service provided**; e.g. Patient Incentive Engagement Tracker. This record must include:
  - The nature of the in-kind item or service;
  - The identity of each beneficiary that received the in-kind item or service;
  - The identity of the individual or entity that furnished the in-kind item or service; and
  - The date the in-kind item or service was furnished.

Code of Conduct

OneCare has a **Code of Conduct** policy that sets forth its commitment to operating in accordance with all applicable laws and clinical, ethical, business, and regulatory standards. All Workforce and Members of the Network engaged in OneCare programs **must cooperate** with OneCare's compliance activities, respond promptly and honestly to any inquiries or audits, and take action to correct any improper activities.

Duty to Report and Non-Retaliation

OneCare will investigate any possible misconduct related to its activities, and may report probable violations of law to the appropriate authority. To ensure that OneCare can perform such activities, **all members of the OneCare Workforce have an affirmative duty to report any suspected violations of applicable laws, compliance program, or OneCare policy.**

OneCare recognizes the importance of open communication and **maintains a strict non-retaliation policy toward anyone who reports a concern in good faith.** Any retaliatory action taken against anyone making a good faith report of improper activities, or participating in an investigation of improper activity, is strictly prohibited.

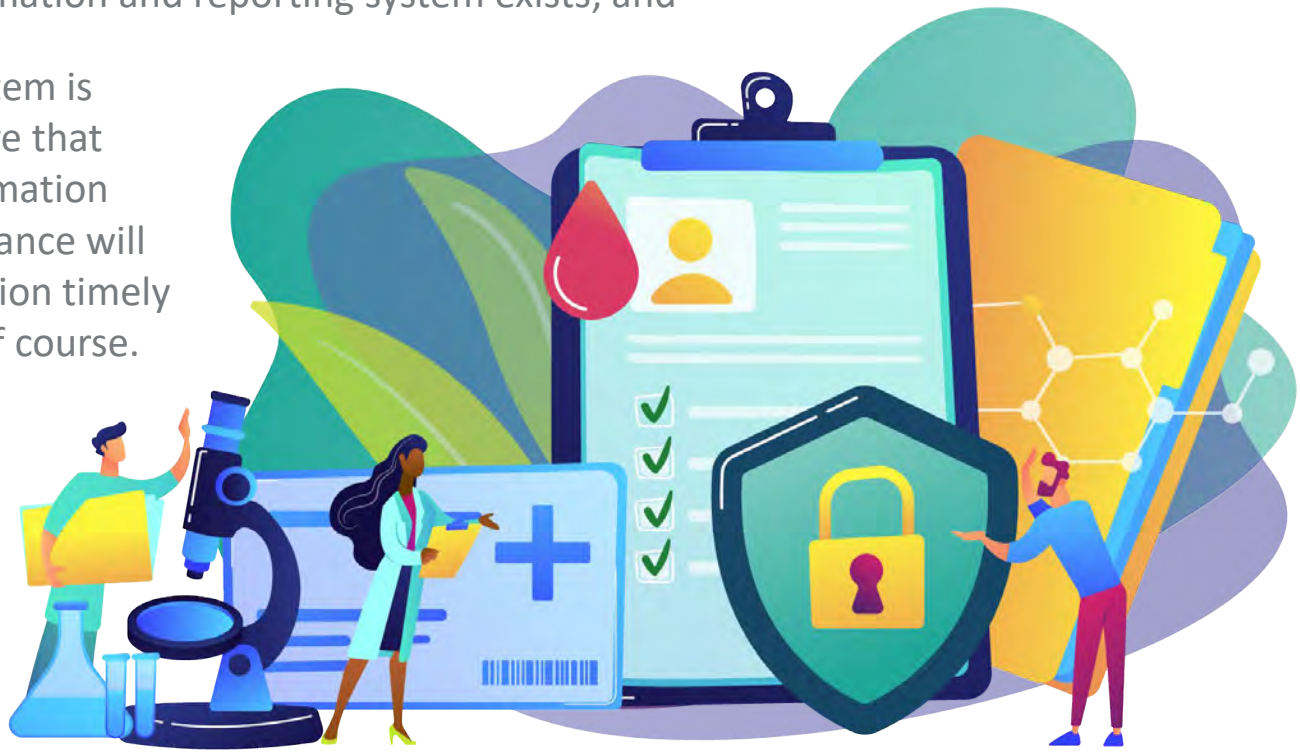
Board Oversight of the OneCare Compliance Program

- Members of the Board of Managers have a **fiduciary obligation** to OneCare when acting on its behalf.

- Boards must act in **good faith** in the exercise of its oversight responsibility for its organization, including making inquiries to ensure:

    1. A corporate information and reporting system exists; and

    2. The reporting system is adequate to assure that appropriate information relating to compliance will come to its attention timely and as a matter of course.



Board Oversight, *continued*

ACO Boards are encouraged to use widely recognized public compliance resources as benchmarks for their organizations, such as:

1. Federal Sentencing Guidelines,
2. Office of the Inspector General (OIG) voluntary compliance program guidance documents, and
3. OIG Corporate Integrity Agreements which can be used as baseline assessment tools for Boards and management in determining what specific functions may be necessary to meet the requirements of an effective compliance program.

Board Oversight, *continued*

- Boards are expected to put forth **meaningful effort** to review the adequacy of the compliance program and functions within the organization.
- Boards should develop a **formal plan to stay well-informed of regulatory landscape and operating environment**, including receiving periodic updates from informed Workforce and review of regulatory resources.
- Boards should have a process in place to ensure **appropriate access to information about the organization.**
- Boards are generally entitled to **rely on the advice of experts** in fulfilling their duties.

Board Oversight, *continued*

The Board of Managers plays a key role in ensuring OneCare is in compliance with the requirements for use of ACO Fraud and Abuse Waivers for certain business arrangements, including:

1. **Participation Waivers:**
    - Making and duly authorizing a bona fide determination that the arrangement is reasonably related to All-Payer Model ACO Activities;
    - Ensuring the arrangement and authorization is documented contemporaneously; and
    - Ensuring the arrangement is publicly disclosed.
2. **Physician Self-Referral Law Waiver:**
    - Ensuring the arrangement is regularly monitored and audited.

OneCare Policies

OneCare Compliance Policies

- 07-02 Compliance
- 07-03 Privacy
- 07-06 Conflict of Interest Policy
- 07-07 Code of Conduct
- 07-08 Compliance Communication, Reporting, and Investigation Policy
- 07-09 Security Policy

OneCare Workforce can find policies internally at the following location:
S:\Groups\Managed Care Ops\OneCare Vermont\Policy and Procedures

OneCare Network Members can find policies on the **OneCare Portal** or by email request at: **HelpDesk@OneCareVT.org**

Speak Up about Compliance Concerns

OneCare Workforce and Network have a **duty to report** possible misconduct or violations of law. If you have a compliance question or concern, you should:

- *Inform your supervisor or manager,*
- *Report your concern directly to the Chief Compliance and Privacy Officer (CCPO), or*
- *Report the concern through the Compliance Hotline, which you may do **anonymously**.*

Chief Compliance and Privacy Officer: **Compliance@OneCareVT.org**

Anonymous inquiries or reports can be made **by phone** to the OneCare Compliance Hotline at:

Local: 802-847-7220

Toll-free: 877-644-7176, Option 3

OneCare Vermont Accountable Care Organization
Board of Managers Resolution to Move to Executive Session
October 19, 2021

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

The Board will now move into executive session in order to discuss subjects that are outside of the scope of the ACO's public meetings. For this meeting, these include: (1) personnel matters; and (2) the status of ongoing contract negotiations.