OneCare Vermont

Policy Update

August 2021

Policy #	Policy Title	Most Recent Approval	Next Board Approval	Does GMCB Have Active Version?	Comments
02-04-PY21	Community Care Coordination Program PY 2021	06/16/2020	N/A	Yes	No planned review for 2021 version of policy
02-04-PY22	Community Care Coordination Program PY 2022	06/15/2021	05/01/2022	Yes	2022 version of policy, effective 1/1/2022
03-03	Data Use	09/17/2019	09/21/2021	Yes	
04-07-PY21	Program Settlement PY 2021	02/16/2021	N/A	Yes	No planned review for 2021 version of policy
04-07-PY22	Program Settlement PY 2022	06/15/2021	05/01/2022	Yes	2022 version of policy, effective 1/1/2022
04-13-PY21	Value Based Incentive Fund PY 2021	02/16/2021	N/A	Yes	No planned review for 2021 version of policy
04-13-PY22	Value Based Incentive Fund PY 2022	06/15/2021	05/01/2022	Yes	2022 version of policy, effective 1/1/2022
04-15-PY21&22	Population Health Management Payments PY 2021 & 2022	02/16/2021	05/01/2022	Yes	
04-16-PY21	Community Care Coordination Payments PY 2021	06/16/2020	N/A	Yes	No planned review for 2021 version of policy
04-16-PY22	Community Care Coordination Payments PY 2022	06/15/2021	05/01/2022	Yes	2022 version of policy, effective 1/1/2022
05-02	Participant and Preferred Provider Appeals	06/15/2021	05/01/2022	Yes	Renamed; formerly Participant Appeals
05-03	Network Development and Composition	06/15/2021	06/01/2022	Yes	Renamed; removed “OneCare” from the title
06-19	Complaints, Grievances, and Appeals for Attributed Lives	03/16/2021	03/01/2022	Yes	
07-02	Compliance	07/20/2021	07/01/2022	Yes	
07-03	Privacy	02/16/2021	02/01/2022	Yes	
07-06	Conflict of Interest	12/15/2020	11/16/2021	Yes	
07-09	Security	02/16/2021	02/01/2022	Yes	
09-01	Quality Improvement and Management	07/20/2021	07/01/2022	Yes	Replaces C02-08 Quality Improvement Procedure; also provided in FY 2022 Certification, Attachment A

Notes:

- Updates since the last report are noted in orange.
- The Next Board Approval date is a future anticipated date and OneCare may adjust dates due to operational priorities.

Summary of Policy Changes
August 2021

The following policies have been approved by the OneCare Board of Managers by the date indicated in the Policy Update table.

- **02-04-PY22 Community Care Coordination Program PY 2022**
  - **Purpose:** To define the core concepts and related responsibilities associated with OneCare's Community Care Coordination Program.
  - **Key Changes:** Policy was edited and substantially reduced to reflect the core concepts of the Care Coordination program and framework. Procedural language was removed to be incorporated into a separate procedure.

- **04-07-PY22 Program Settlement PY 2022**
  - **Purpose:** To document the principles guiding the annual settlement of ACO Programs with Providers bearing upside and downside risk and to establish an Accountability Pool of funds designated for use in payment of any Shared Losses generated by an ACO Program.
  - **Key Changes:** No substantive changes; all edits are for the purpose of improved clarity.

- **04-13-PY22 Value Based Incentive Fund PY 2022**
  - **Purpose:** To establish the apportionment and distribution of qualifying incentive payments from the Value Based Incentive Fund to Participants and Preferred Providers delivering high-quality care.
  - **Key Changes:** No substantive changes; all edits are for the purpose of improved clarity.

- **04-16-PY22 Community Care Coordination Payments PY 2022**
  - **Purpose:** To establish the calculation and distribution of Community Care Coordination payments to OneCare Network Participants, Preferred Providers and Collaborators in accordance with OneCare's Care Coordination Model.
  - **Key Changes:** The policy establishes a $1.50 base PMPM for care coordination efforts with an additional incentive of $0.25-$0.50 PMPM payment for practices in the top two thirds of the network for risk-adjusted total cost of care for attributed lives. The policy also names a stakeholder engagement process to determine payments for other currently funded partners in the care coordination program. This policy will be amended to include these payments once the engagement process concludes.

- **07-02 Compliance**
  - **Purpose:** To establish the Compliance Program whereby OneCare trains, audits, and monitors its Workforce and Network on Applicable Laws; provides mechanisms to report and investigate potential and actual violations; and implements the appropriate corrective actions in response.
  - **Key Changes:** No substantive changes; all edits are for the purpose of improved clarity.

- **09-01 Quality Improvement and Management** *(New Policy)*
  - **Purpose:** To define and outline key requirements of quality improvement and management efforts at OneCare and to serve as a guide for strategic implementation of efforts to improve quality of care provided to Attributed Lives.

Policy Number & Title:	02-04-PY22 Community Care Coordination Program Policy PY 2022
Responsible Department:	Clinical
Author:	Lindsay Morse, Director, Care Coordination
Original Implementation Date:	January 1, 2021
Revision Effective Date:	January 1, 2022

I. **Purpose:** To define the core concepts and related responsibilities associated with OneCare's Community Care Coordination Program.

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

III. **Definitions:** Capitalized terms have the same definition as defined in OneCare's *Policy and Procedure Glossary*.

IV. **Policy**

A. OneCare Community Care Coordination Core Concepts

OneCare Care Coordination Program enhances and supports the system of care in which all Vermonters have access to high quality, patient-centric, interdisciplinary, community-based care coordination across the continuum, in alignment with payers, state agencies, and other partners.

Insights including Care Coordination rates, gaps in care, quality measure performance, trends in utilization, and total cost of care are incorporated to support the growth and direction of Health Service Areas and ACO wide Care Coordination efforts.

B. Responsibilities

OneCare:

- 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 to support ongoing process metrics and outcomes monitoring.
- OneCare will provide financial support for Care Coordination efforts through various OneCare payment programs.
- OneCare Care Coordination Program will review trends in overall utilization, costs of care, and health outcomes and recommend refinements or enhancements through established governance.
- OneCare Care Coordination Team will collaborate and partner with Network members to support information sharing, best practices, and opportunities to positively impact Care Coordination efforts.

Network:

- The Network will actively and collaboratively work to develop and refine internal and cross-organizational workflows to facilitate effective, evidence informed Care Coordination for Attributed Lives with the goal of improved clinical and financial outcomes.
- Network Participants will designate a resource to review and act upon OneCare provided data, engage in purposeful outreach, and provide Care Coordination for their Attributed Lives.
- Network Participants will align with the OneCare Care Coordination best practices and utilize associated software and analytic tools.

- The aforementioned Network responsibilities are high level and entail specific criteria, actions and documentation outlined in the 2022 OneCare Care Coordination Payment Model Guidance Document.

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

VI. References:

- OneCare's Policy and Procedure Glossary

VII. Related Policies/Procedures:

- 04-16-PY22 Community Care Coordination Payments PY 2022 Policy
- C02-15 Care Coordination Quality Audit and Monitoring Procedure

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

Management Approval:

Lindsay Morse, RN — 06/22/2021
Director, Care Coordination — Date

Norman S. Ward MD — 06/29/2021
Chief Medical Officer — Date

Sara E Barry — 06/29/2021
Chief Operating Officer — Date

Board of Managers Approval:

John Brumsted — 6/30/2021
Chair, OneCare Vermont Board of Managers — Date

Policy Number & Title:	04-07-PY22 Program Settlement PY 2022
Responsible Department:	Finance
Author:	Derek Raynes, Director, Payment Reform
Original Implementation Date:	July 25, 2019
Revision Effective Date:	January 1, 2022

I. Purpose: (1) To document the principles guiding OneCare Vermont's ("OneCare") annual settlement of ACO Programs with Providers bearing upside and downside risk, respectively, for Shared Losses and Shared Savings generated by an ACO Program for a Program Year ("Settlement"); and (2) to establish an Accountability Pool of funds designated for use in payment of any Shared Losses generated by an ACO Program.

II. Scope: Applicable to all Participants and Preferred Providers.

III. Definitions: Capitalized terms have the same definition as defined in OneCare's *Policy and Procedure Glossary*. For the purposes of this Policy, the terms below have the following meanings:

Accountability Pool means a pool of funds into which Accountable Providers make monthly contributions, which is designated solely for funding any liability for Shared Losses generated by an ACO Program. An Accountable Provider's upside and downside risk, respectively, for Shared Losses and Shared Savings generated by an ACO Program is limited to the amount of their contribution to the Accountability Pool.

Accountable Providers may defer making monthly contributions to the Accountability Pool in favor of being invoiced for their portion of any Shared Losses at year end.

Accountable Provider means a Participating Provider that has been Assigned Attributed Lives for an ACO Program, and is at downside risk for Shared Losses up to the amount of their contributions to the Accountability Pool.

Risk-Bearing Entity ("RBE") means a Network hospital that bears upside and downside risk, respectively, for Shared Losses and Shared Savings generated by the performance of its HSA against an ACO Program's cost-of-care targets.

IV. Policy: At Settlement of each ACO Program, OneCare will (1) apportion and distribute any Shared Savings, and collect and remit any Shared Losses, generated by an ACO Program; (2) disburse funds held in the Accountability Pool; and (3) facilitate any required exchanges of cash.

A. General

1. Hospitals will serve as the Risk Bearing Entity ("RBE") on behalf of each individual HSA.

2. Each individual HSA will be subject to a limitation on the Shared Savings its RBE and Accountable Providers are eligible to receive. Likewise, each individual HSA will have a limitation on the potential downside risk for payment of Shared Losses.

3. Limitations on Shared Savings and Shared Losses are calculated separately for each ACO Program and for each HSA.

B. Financial Settlement of Program Performance

1. For ACO Programs in which Accountable Providers bear risk for both Shared Losses and Shared Savings:

    a. Accountable Providers will contribute $1.50 PMPM to its HSA's Accountability Pool based on member months determined by the same calculation used for PHMP payments in accordance with *04-15 Population Health Management Payments Policy*.

    b. The Accountability Pool contributions can be made monthly as part of the Accountable Provider's program payment, or deferred (with a year-end settlement for Shared Savings or Shared Losses). Accountable Providers who wish to defer Accountability Pool contributions must indicate their preference in writing.

    c. When OneCare is liable for Shared Losses generated by an ACO Program:

        i. Shared Losses will be allocated to the participating HSAs based on the proportion of lives Assigned to that HSA for the Performance Year.

        ii. The Accountability Pool's funds will be used to pay the HSA's portion of Shared Losses owed to the Payer. Any Shared Losses remaining after the HSA's Accountability Pool has been exhausted will be paid by the RBE.

        iii. Accountable Providers who have deferred making contributions to the Accountability Pool will be invoiced for their share of any liability for Shared Losses, which must be paid within thirty (30) days of the invoice date. Accountable Providers who fail to remit payment in a timely manner will be in bad standing and may be subject to corrective action, such as recoupment of funds, and/or loss of other benefits of good standing.

    d. When OneCare earns Shared Savings generated by an ACO Program:

        i. The funds held in the Accountability Pool will be refunded and there will be no further liability for deferred contributions.

        ii. Shared Savings designated for certain Budgeted Expenses will be allocated accordingly, with any remaining Shared Savings allocated as follows:

            1. 90% to the participating HSAs based on the proportion of lives Assigned for the Performance Year, with Accountable Providers receiving proportional shares of those savings up to an amount equal to the sum of all Accountability Pool contributions made or deferred by each during the Performance Year, and with any remainder then being paid to the HSA's RBE.
            2. 10% to be used to reward HSAs with exceptional outcomes within the Performance Year (as determined by the Board of Managers).

2. For ACO Programs in which Accountable Providers may earn Shared Savings only (no downside risk):

a. Shared Savings allocated for certain Budgeted Expenses will be allocated accordingly, with any remaining Shared Savings allocated as follows:
    i. 90% to the participating HSAs based on the proportion of lives Assigned for the Performance Year, with Accountable Providers receiving proportional shares of those savings up to an amount equal to the sum of all Accountability Pool contributions made or deferred by each during the Performance Year, and with any remainder then being paid to the HSA's RBE, and
    ii. 10% to be used to reward HSAs with exceptional outcomes within the Performance Year (as determined by the Board of Managers).

3. For ACO Programs for which full risk is held centrally by OneCare, final settlement calculations will be approved by the Finance Committee and Board of Managers and no Shared Savings or Shared Losses will be owed to or from RBEs or Accountable Providers. The settlement process for those ACO Programs will still include Other Monies Owed as described in this policy.

C. Other Monies Owed

1. For ACO Programs with unreconciled fixed payments:

    a. Hospital Participants: To minimize the potential negative impact of changes in clinical referral patterns between hospitals or HSAs, the component of each hospital Participant's fixed payment for care provided to patients attributed to another HSA will be determined at the Network level, rather than the HSA level, rendering compensation for this component proportionally equivalent across the Network. Consequently, liability for monies owed by or credited to a hospital Participant may be accounted for at Settlement.

    b. Comprehensive Payment Reform (CPR) Practices: There will be no reconciliation of the fixed payments. Other reconciliations as defined in *04-08 Comprehensive Payment Reform PY 2022* may apply.

    c. If there is a fixed payment reconciliation between OneCare and a Payer, the reconciled amount will be applied to RBEs and Accountable Providers in a proportional manner.

2. For ACO Programs with reconciled fixed payments:

    a. Hospitals: The fixed payment paid to the hospital Participant will be reconciled in full to the FFS equivalent value. This can result in an amount owed to, or due from the hospital Participant, as accounted for in the Performance Year settlement.

    b. Comprehensive Payment Reform (CPR) Practices: There will be no reconciliation of the fixed payments. Any balance owed to or due from the Payer will be allocated to hospitals pro-rata based on the Shared Savings or Shared Losses in the ACO Program. Other reconciliations as defined in *04-08 Comprehensive Payment Reform PY 2022* may apply.

D. Cash Exchange

1. Once settlement calculations have been approved by the Board, all RBEs owing money to

OneCare must submit payment within thirty (30) days of the date of the invoice. OneCare reserves the right to recoup any past due amount owed to OneCare from future payments to the owing RBE.

3. All RBEs, Participants and/or Preferred Providers owed money from OneCare will receive payments within thirty (30) days of final approval of settlement calculations, but payment will be contingent upon OneCare receiving payment from the Payer(s) and/or other network RBEs.

E. Ongoing Review: Some ACO Program Agreements allow for review of results after final settlement. If an ACO Program Payer reviews and changes settlement calculations, it is considered a material change in circumstances, permitting reconsideration of settlements previously transacted under this policy.

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

VI. References:

- OneCare's Policy and Procedure Glossary
- OneCare's Program Agreements with Payers

VII. Related Policies/Procedures:

- 04-15-PY21&22 Population Health Management Payments PY 2021 & 2022
- F04-03 OneCare Vermont Shared Savings Calculation and Distribution Process
- 04-08 Comprehensive Payment Reform PY 2022 Policy

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

Management Approval:

Derek S. Raynes — June 23, 2021
Director, Payment Reform — Date

6/28/2021
Vice President, Finance — Date

Sara E Barry — 06/29/2021
Chief Operating Officer — Date

Board of Manager Approval:

John Brumsted — 6/30/2021
Chair, OneCare Board of Managers — Date

Policy Number & Title:	04-13-PY22 Value Based Incentive Fund PY 2022
Responsible Department:	Finance
Author:	Derek Raynes, Director of Payment Reform
Original Implementation Date:	January 1, 2020
Revision Effective Date:	January 1, 2022

I. Purpose: To establish a policy for the apportionment and distribution of qualifying incentive payments from the Value-Based Incentive Fund to Participants and Preferred Providers delivering high-quality care.

II. Scope: Applicable to members of OneCare's Network.

III. Definitions: Capitalized terms have the same definition as defined in OneCare's *Policy and Procedure Glossary*. For purposes of this policy, the terms below have the following meanings:

Value-Based Incentive Fund ("VBIF") means a fund generated from Participation Fees, which is used to reward Participants and Preferred Providers for delivering high-quality care, as evidenced by the achievement of certain quality metrics as set forth by the Population Health Strategy Committee and endorsed by the Board of Managers.

IV. Policy: OneCare will allocate amounts required in ACO Program Agreements and/or amounts authorized by the Board of Managers into the VBIF, which shall be used for quality incentive payments to Participants and Preferred Providers. For ACO Program Agreements specifically referencing the VBIF, the amount payable to Participants and Preferred Providers will be determined by the terms of the ACO Program Agreement.

A. **Distribution Plan for VBIF Incentive Payments:**

1. 70% to Participants who are Primary Care Providers based on Attributed Lives;
2. 20% to other Participants and Preferred Providers based on the achievement of the quality metrics; and
3. 10% to the Network in the form of quality improvement investment(s) or projects proposed by OneCare management and approved by the Board of Managers.

B. The Finance Committee and Board of Managers will review and approve of all VBIF amounts and disbursements. VBIF disbursements calculated to be $0.01 or more shall be upwardly adjusted to a minimum of $100.

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

VI. References:

- OneCare's *Policy and Procedure Glossary*
- OneCare DVHA Program Agreement

VII. Related Policies/Procedures:

- 04-10-PY22 Participation Fees PY 2022 Policy
- F04-01 OneCare Vermont Value Based Incentive Fund Calculation and Distribution Procedure
- F04-02 VMNG Primary Care Alignment Strategy Procedure

- F04-08 OneCare Vermont Primary Care Case Management and Population Health Management Payment Distribution Procedure

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Management Approval:

Derek S. Raynes	June 23, 2021
Director, Payment Reform	Date
	6/28/2021
Vice President, Finance	Date
Sara E Barry	06/29/2021
Chief Operating Officer	Date

Board of Manager Approval:

John Brumsted	6/30/2021
Chair, OneCare Board of Managers	Date

Policy Number & Title:	04-16 Community Care Coordination Payments PY 2022
Responsible Department:	Finance, Analytics, Clinical
Author:	Derek Raynes, Director, Payment Reform
Original Implementation Date:	July 1, 2017
Revision Effective Date:	January 1, 2022

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

II. Scope: This Policy describes the program OneCare uses to make payments to Participants, Preferred Providers and Collaborators (collectively "Network") for performing Community Care Coordination activities for defined populations.

III. Definitions: Capitalized terms have the same definition as defined in OneCare's *Policy and Procedure Glossary*. For the purposes of this Policy, the term below has the following meaning:

Risk-Adjusted Total Cost of Care: the PMPM total cost of care for Attributed Lives assigned by TIN, adjusted using the Johns Hopkins concurrent risk score. The Risk-Adjusted Total Cost of Care will be measured separately for each ACO Program and for adult and pediatric patients

IV. Policy

A. Supplemental Care Coordination Payments

1. For Primary Care Provider Participants grouped by TIN:

   OneCare will pay a $1.50 PMPM based on member months determined by the same calculation used for PHMP payments in accordance with *04-15 Population Health Management Payments Policy*.

   OneCare will pay an additional $0.25 PMPM bonus to Primary Care Provider Participants whose Risk-Adjusted Total Cost of Care is between the 33rd and 67th percentile for the Network, and a $0.50 PMPM bonus to Primary Care Provider Participants whose Risk-Adjusted Total Cost of Care is between the 1st and 32nd percentile for the Network.

   The above referenced additional bonus payments will be made after three months of claims runout.

2. For all other provider types historically eligible for care coordination payments, OneCare will facilitate a stakeholder engagement process to determine the specific role of each provider type in the OneCare care coordination program model, as outlined by the 02-04-PY22 Community Care Coordination Program PY 2022 policy.

B. Actions/Responsibilities

Any party receiving payment from OneCare for Community Care Coordination services certifies, in taking that payment, that is has satisfied all requirements of the *First Amended and Restated Risk Bearing Participant and Preferred Provider Agreement*, together with all applicable policies and procedures. OneCare's Community Care Coordination team will provide support to each Health Service Area to ensure performance in accordance with program expectations.

C. Monitoring & Auditing

Monitoring and auditing is shared between the clinical, analytics, and finance departments. The clinical department will monitor Provider performance in accordance with the Community Care Coordination program expectations. The Finance Department will monitor, track and audit any additional bonus PMPM payments.

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

VI. References:

- Vermont All-Payer ACO Model, Vermont Medicare ACO Initiative Participation Agreement
- State of Vermont – Department of Vermont Health Access Medicaid Next Generation Model
- Blue Cross Blue Shield of Vermont Next Generation Model ACO Program (QHP ONLY)
- OneCare's ACO Collaboration Agreements
- OneCare's Policy and Procedure Glossary

VII. Related Policies/Procedures:

- C02-06 Care Coordination Training and Responsibilities Procedure
- 02-04-PY22 Community Care Coordination Program PY 2022 Policy

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Management Approval:

Derek S. Raynes — June 23, 2021
Director, Payment Reform — Date

6/28/2021
Vice President, Finance — Date

Sara E Barry — 06/29/2021
Chief Operating Officer — Date

Board of Managers Approval:

John Brumsted — 6/30/2021
Chair, OneCare Vermont Board of Managers — Date

Policy Number & Title	07-02 Compliance Policy
Responsible Department:	Compliance
Author:	Greg Daniels, Chief Compliance and Privacy Officer
Original Implementation Date:	September 23, 2013
Revision Effective Date:	July 20, 2021

I. Purpose: This Compliance Policy ("Policy") sets forth the elements of the OneCare Compliance Program and establishes the organization of the Compliance Program whereby OneCare trains its Workforce and Network on Applicable Laws, audits and monitors its Workforce and Network for compliance with Applicable Laws, provides mechanisms to report potential and actual violations of Applicable Laws or the terms of the Compliance Program, investigates reports of such violations, and implements the appropriate corrective actions in response.

II. Scope: Applicable to all of OneCare's Workforce, Officers, Board of Managers, Committees, the Network, and anyone else who conducts business with or on behalf of OneCare.

III. Definitions: Capitalized terms have the same definition as defined in *OneCare's Policy and Procedure Glossary*. For purposes of this Policy, the below terms have the following meanings:

Applicable Laws means all federal state and local laws, rules and regulations and the terms and conditions set forth in the policies, procedures and payer agreements of OneCare. Applicable Laws shall include, but not be limited to, the following: (a) federal criminal law; (b) the federal False Claims Act (31 U.S.C. 3729 et seq.) and state law equivalents; (c) the federal anti-kickback statute (42 U.S.C. 1320a-7b{b)) and state law equivalents; (d) the federal civil monetary penalties law (42 U.S.C. 1320a-7a) and state law equivalents; (e) the federal physician self-referral law (42 U.S.C. 1395nn) and state law equivalents; (f) the federal and state antitrust laws (15 U.S.C. 1 et seq. and 10 M.R.S.A. § 1101-1102-A and 5 M.R.S.A. § 207, respectively); (g) the federal and state patient privacy protection laws, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"); (h) the terms and conditions set forth in the Vermont All-Payer Accountable Care Organization Model ("All-Payer Model") Agreement among the Centers for Medicare & Medicaid Services ("CMS"), the Governor of the State of Vermont, the Green Mountain Care Board ("GMCB") and the Vermont Agency for Human Services ("AHS"), and all related contracts among these parties in furtherance of the All-Payer Model; (i) those regulating and governing the formation and operation of accountable care organizations ("ACOs") and other publicly funded health care programs, including those set forth by the GMCB or the State of Vermont through AHS; (j) ethical standards set forth in OneCare's Code of Conduct; and (k) the terms of all other agreements of OneCare with CMS and other public and private payers.

Compliance Authorities means any and all laws, regulations, guidelines, or other authorities applicable to OneCare.

IV. Policy

The OneCare Compliance Program is comprised of the following elements:

1. Designation of CCPO

OneCare's Chief Compliance and Privacy Officer ("CCPO") shall oversee compliance matters on behalf of OneCare. The CCPO shall report directly to the Board and the Chief Executive Officer ("CEO"). The distinct functions of Legal and Compliance shall remain separate, and the CCPO shall not serve or substitute as legal counsel for the ACO. The CEO shall not have authority to interfere

with the independent judgment of the CCPO, or impede the CCPO's direct access to the Board of Managers or Officers when deemed necessary and appropriate by the CCPO.

To effectively oversee the Compliance Program, the CCPO shall:

- Oversee and monitor OneCare's Compliance Program;
- Develop and implement a compliance education and training program;
- Develop policies and procedures that are effective and encourage the reporting of non-compliance or suspected fraud, waste and abuse;
- Serve as a knowledgeable resource to organizational and operational matters relating to compliance;
- Develop, implement and monitor an annual Work Plan setting forth the priorities and initiatives of the Compliance Department and the Compliance Committee;
- Ensure the effectiveness of the Compliance Program through auditing and monitoring, identifying areas of risk, and enforcing corrective actions;
- Report regularly to the Audit Committee, the Board, and the CEO on compliance matters, audit findings, investigations, assessments and advising OneCare on recommended corrective actions arising from audits and investigations;
- Review and revise elements of the Compliance Program, including compliance-related policies and procedures, to address changes in Applicable Law and incorporate recommendations arising from audits and investigations;
- In collaboration with the VP of Finance and Payment Reform and the Audit Committee, oversee the repayment of overpayments to the extent OneCare receives any overpayment for services, and other applicable payment-related compliance matters; and
- Receive, document, and investigate reports of potential non-compliance and fraud, waste and abuse with the Compliance Program or Applicable Laws.

The CCPO may delegate responsibilities to members of the Compliance department, provided that the CCPO shall remain responsible for all such delegated activities.

2. Designation of the Compliance Committee

There shall be a Compliance Committee comprised of OneCare Officers, which shall be chaired by the CCPO and shall operate in the accordance with the terms of the Compliance Committee Charter. The CCPO shall represent the Compliance Committee when reporting to the Board of Managers on ongoing oversight activities through the Audit Committee. The Compliance Committee shall provide oversight of the Compliance Program, produce an annual work plan for the upcoming program year, and oversee investigations of reported or suspected instances of non-compliance. For more information on the work and structure of the Compliance Committee, please see the *OneCare Compliance Committee Charter*.

3. Designation of the Board Audit Committee

There shall be an Audit Committee of the Board that works with and provides input to the CCPO in developing a detailed and effective audit and monitoring plan with respect to the Compliance Program. The CCPO shall periodically report on internal and external audits of the Compliance Program to the Audit Committee. The Audit Committee shall be comprised of members of the Board, the CCPO and the CEO, or designee, as further described in the *OneCare Audit Committee Charter*.

4. Policies and Procedures

OneCare shall develop and maintain policies and procedures to ensure that the ACO business and operations are conducted in accordance with this Policy, the *Code of Conduct*, and all Applicable Laws.

OneCare shall adopt and maintain policies and procedures to address the following Compliance Program functions:

i. Internal audit and monitoring to ensure compliance with this Policy and Code of Conduct;

ii. Fraud, waste, and abuse laws, including prohibitions found in federal and state criminal law, such as the Anti-Kickback Statute, Stark laws, False Claims Act, referrals among ACO members, gainsharing Civil Monetary Penalties ("CMP"), and prohibitions on patient inducements, including to address the prohibition on unlawful referrals;

iii. ACO Fraud and Abuse Waivers as approved by the Board of Managers and granted by CMS under the Vermont All-Payer Model;

iv. Non-retaliation;

v. Record retention and destruction (General 10-year retention period for ACO documents);

vi. Information security and HIPAA privacy and security rules compliance, including breach notification procedures; and

vii. Reporting, investigating and correcting violations of the law or the Code of Conduct.

To the extent permitted by law, Network members shall ensure their own compliance policies and procedures sufficiently address legal and regulatory requirements related to ACO activities, and reflect the requirements of this Policy.

5. Compliance Education and Training

OneCare recognizes the importance of communicating its Compliance Program to its Workforce and Network. OneCare requires its Workforce and Network to complete annual compliance training and to attend additional trainings on related topics available by electronic and in-person means.

Examples of some of the topics to be address by OneCare's training programs are as follows:

- Physician self-referral, Anti-Kickback statutes and CMP penalties, including the application of CMS final waivers in connection with ACO start-up and ongoing operations;

- How to detect potential fraud, waste, and abuse and the parameters for reporting any suspicions to the CCPO including use of the Compliance Hotline and how to make confidential reports of potential violations;

- ACO beneficiary rights;

- ACO Marketing requirements;

- Non-retaliation;

- Conflict of interest requirements;

- Data sharing, other information security requirements, HIPAA Privacy and Patient Confidentiality; and

- Requirements of Medicaid reimbursement and utilization of services as may be directed, or waived, by DVHA.

In addition to annual trainings, other education may be provided as necessary to address potential compliance risks as identified during internal or external audits. The CCPO shall keep a record of education and trainings provided to OneCare's Workforce and Network and attendance lists as applicable.

6. Auditing and Monitoring

OneCare maintains a program of auditing and monitoring to routinely identify compliance risk areas specific to ACOs. OneCare will monitor compliance with all risk areas identified and will regularly review metrics related to cost, utilization and quality for indications of program integrity concerns. Findings of non-compliance through auditing and monitoring will be analyzed further to determine the scope and breadth of any potential problems.

The CCPO may recommend to the CEO or the Board that independent accounting firms or consultants be retained to review areas of OneCare's operations to determine whether they meet the requirements of the Compliance Program.

OneCare will retain the records of audit reports in compliance with OneCare's Records Retention Policy. For more information on auditing and monitoring, please refer to OneCare's Compliance Auditing Procedure and Audit Toolkit.

7. Exclusion Screening of Network

OneCare and its Network will not knowingly hire or contract with any individual or entity that has been excluded from participation in any federal health care program. Network providers and entities will be screened against the OIG List of Excluded Individuals and Entities ("OIG LEIE") and the federal System for Award Management ("SAM") Exclusion Database prior to initial contracting and monthly thereafter. Documentation of monthly exclusion screening will be maintained by the CCPO.

The Network is required to conduct such screenings and assure OneCare that there are no excluded or debarred individuals in their employ. The Network will immediately notify OneCare of the identity of any person or entity who provides services to or on behalf of OneCare and its Network that: (a) has been excluded according to the OIG LEIE or SAM; (b) has been subject to any conviction or adverse action that subjects the individual to federal health care program exclusion under 42 U.S.C. 1320a-7; or (c) has a history of health care program integrity issues.

OneCare will immediately take remedial action to remove and/or terminate employee and contractual relationships with any excluded entity or individual, and will report such removal to payers and others as necessary under Applicable Laws.

8. Confidential Communications, Reporting and Non-Retaliation

OneCare shall maintain a confidential communication mechanism so Workforce, Network and others may report compliance concerns without concern of retaliation. Workforce are obligated to report to CCPO conduct he or she knows or reasonably believes to be in violation of the Compliance Program and all Applicable Laws.

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

Questions regarding OneCare's Compliance Program, or to report a potential violation of Applicable Laws or fraud, waste or abuse, you may send an email to the CCPO at: Compliance@OneCareVT.org.

Anonymous inquires or reports may be made by phone by calling the Compliance Hotline at: 802-847-7220 / 877-644-7176, Option 3.

For further information on reporting of potential or actual violations of Applicable Laws, confidentiality and non-retaliation, please see OneCare's *Compliance Communication, Reporting, and Investigation* and *Code of Conduct* policies.

9. Responding to Compliance Issues

OneCare commits to timely and full cooperation with governmental inquiries, audits and investigations, and the adherence to standards and protocols that involve ACO Legal Counsel, the CCPO, as well as the compliance officers or their equivalent within the Network. OneCare will take appropriate corrective action in response to any identified compliance issues. Such corrective action may include additional training, revision of policies and procedures and/or Workforce discipline. For more information investigations, please see OneCare's please see OneCare's *Compliance Communication, Reporting, and Investigation* policy.

10. Conflicts of Interest

OneCare's *Conflict of Interest* policy requires annual and ongoing disclosures of relevant financial interests of Key Persons. The policy provides a process for determining whether a conflict of interest exists addressing any conflicts that arise, and remedial steps that will be taken in the event of non-compliance with the policy. Annual conflicts of interest training will be provided to the Board of Managers and other Key Persons as so determined by the CCPO. For detailed information on reporting potential or actual conflicts of interests, review process and mitigation steps, please see OneCare's *Conflict of Interest* policy.

11. Code of Conduct

OneCare has established a *Code of Conduct* policy which establishes the general ethical and compliance expectations for OneCare Workforce, Network and others who perform functions or

ACO related activity services for or on behalf of OneCare. For details on established ethical and compliance standards, please see OneCare's *Code of Conduct* policy.

12. **Cooperation with Regulators**

    OneCare will work cooperatively with and maintain effective communication with payers and regulatory agencies. In doing so, it is essential that OneCare's legal rights are protected. The Workforce must understand that communications and cooperation with payers and regulatory agencies should follow the appropriate procedures for such communications, and if any Workforce member receives an inquiry, subpoena or other legal document regarding OneCare's business which is not routine in nature, they must immediately notify their direct manager and the CCPO immediately.

    While OneCare is a participant in the Vermont All-Payer Model, all program integrity requirements set forth in any program agreement between OneCare and Department of Vermont Health Access ("DVHA") shall be included as part of this Compliance Program. The CCPO will cooperate and maintain communication with DVHA's Program Integrity Unit to make prompt reports or referrals of fraud, waste, and abuse and removal of an excluded entity or individual from the Network or work related directly or indirectly to OneCare, and will participate in the development of corrective action plans.

13. **Monitoring Provision of Reports to DVHA**

    OneCare will monitor on a regular basis through its Committees and Board reports relating to key metrics of cost, utilization, and quality to identify variance that may inform program integrity functions. Reports monitored and made available to DVHA shall be incorporated into the mutually agreed upon *ACO Reporting Manual*.

V. Review Process: This policy shall be reviewed annually and updated to be consistent with revisions in laws, regulations and contractual requirements.

VI. References:

- OneCare's Program Agreements with Payers and requirements
- ACO Reporting Manual for the Vermont Medicaid Next Generation Program
- GMCB Rule 5.000: Oversight of Accountable Care Organizations
- OneCare Compliance Committee Charter
- OneCare Audit Committee Charter
- OneCare's Policy & Procedure Glossary

VII. Related Policies/Procedures:

- 07-06 Conflict of Interest Policy
- 07-07 Code of Conduct Policy
- 07-08 Compliance Communication, Reporting, and Investigation Policy
- CP07-03 Compliance Auditing Procedure and Audit Toolkit

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

Management Approval:

Gregory Daniels — July 26, 2021

Chief Compliance and Privacy Officer — Date

Sara E Barry — 08/03/2121

Chief Operating Officer — Date

Board of Managers Approval:

John Brumsted — 8/17/2021

Chair, OneCare Vermont Board of Managers — Date

Policy Number & Title:	09-01 Quality Improvement and Management
Responsible Department:	Quality
Author:	Josiah Mueller, Director, Value Based Care
Original Implementation Date:	July 20, 2021
Revision Effective Date	July 20, 2021

I. **Purpose:** To define and outline key requirements of quality improvement and management efforts at OneCare Vermont (OneCare).

II. **Scope:** Applicable to the OneCare Workforce, Board of Managers, Committees, and Network.

III. **Definitions:** Capitalized terms have the same definition as defined in *OneCare's Policy and Procedure Glossary*. For purposes of this policy, the terms below have the following meanings:

Quality Improvement Project means a strategy, plan, and associated tasks to address improvements in performance of the quality of care provided by Participating Providers to Attributed Lives.

Quality Improvement Workgroup means a Subcommittee of Utilization Review Committee (URC), charged with developing, approving, monitoring and evaluation of quality improvement work.

OneCare Quality Team means the OneCare team responsible for supporting quality improvement and management operational efforts within the OneCare ACO Network.

IV. **Policy:** This Quality Improvement and Management Policy serves as a guide for strategic implementation of efforts to improve quality of care provided to Attributed Lives. The policy is described by several key focus areas which are outlined below, and is guided by OneCare's ACO Program Agreements with Payers.

A. **Annual Quality Improvement Strategy Work Plan:** OneCare Quality Team shall annually define OneCare's quality improvement and management priorities.

1. The work plan will include specific, measureable, time-bound performance goals and ongoing assessments of progress toward these goals.
2. The work plan shall be reviewed by OneCare's Director of Value Based Care and Chief Medical Officer, subsequently presented to the Population Health Strategy Committee for approval.

B. **Quality Measurement:** In accordance with applicable law and respective ACO Program Agreements with Payers, OneCare shall annually evaluate and report on quality of care against defined measures and standards.

C. **Monitoring and Quality Assurance:** OneCare will engage in monthly review of subsets of available quality performance data via the Quality Improvement Workgroup. This review will include assessment and evaluation of performance (including gaps and variations in care), determination of need for intervention, implementation of necessary intervention, and ongoing monitoring of these efforts.

D. **Engagement:** The OneCare Quality Team will gather feedback from the Patient and Family Advisory Committee and Network members to identify opportunities to facilitate and support ACO Network engagement of Attributed Lives and/or other supportive parties in quality improvement and management efforts.

E. **Reporting:** OneCare shall adhere to quality and utilization reporting requirements as outlined in respective ACO Program Agreements with Payers and as required by law.

F. **Right to Inspection:** In accordance with the terms in ACO Program Agreements with Payers, OneCare shall provide reasonable support to Payer requests for inspection of quality improvement related books, records, or contracts.

V. Review Process: This policy shall be reviewed annually and updated to be consistent with requirements set forth by OneCare Board of Managers, OneCare leadership, ACO Program Agreements with Payers, and regulatory bodies.

VI. References:

- OneCare's ACO Program Agreements with DVHA
- OneCare's ACO Program Agreement with Medicare
- OneCare's ACO Program with Blue Cross Blue Shield of Vermont (Primary and QHP)
- OneCare's ACO Program with MVP
- GMCB Rule 5.000: Oversight of Accountable Care Organizations
- OneCare's Policy and Procedure Glossary

VII. Related Policies/Procedures:

- 03-03 Data Use Policy
- 03-05 Data Transparency Policy
- 04-13-PY21 Value Based Incentive Fund PY 2021 Policy

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Management Approval:

Josiah Mueller — 7/21/2021
Director, Value Based Care — Date

Victoria E Loner — 08/09/2021
Chief Executive Officer on behalf of Chief Medical Officer — Date

Sara E Barry — 08/03/2021
Chief Operating Officer — Date

Board of Managers Approval:

John Brumsted — 8/17/2021
Chair, OneCare Vermont Board of Managers — Date