OneCare Vermont

Policy Update

July 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	6/16/2020	N/A	Yes	No planned review for 2021 version of policy
03-03	Data Use	9/17/2019	9/21/2021	Yes	
04-07-PY21	Program Settlement PY 2021	2/16/2021	N/A	Yes	No planned review for 2021 version of policy
04-13-PY21	Value Based Incentive Fund PY 2021	2/16/2021	N/A	Yes	No planned review for 2021 version of policy
04-15-PY21&22	Population Health Management Payments PY 2021 & 2022	2/16/2021	5/1/2022	Yes	
04-16-PY21	Community Care Coordination Payments PY 2021	6/16/2020	N/A	Yes	No planned review for 2021 version of policy
05-02	Participant and Preferred Provider Appeals	6/15/2021	5/1/2022	Yes	Renamed; formerly Participant Appeals
05-03	~~OneCare~~ Network Development and Composition	6/15/2021	6/1/2022	Yes	Renamed; removed “OneCare” from the title
06-19	Complaints, Grievances, and Appeals for Attributed Lives	3/16/2021	3/1/2022	Yes	
07-02	Compliance	7/20/2021	7/1/2022	No	Policy will be provided upon receipt of required signatures
07-03	Privacy	2/16/2021	2/1/2022	Yes	
07-06	Conflict of Interest	12/15/2020	11/16/2021	Yes	
07-09	Security	2/16/2021	2/1/2022	Yes	

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.

OneCare Vermont

Summary of Policy Changes
July 2021

The following policies were approved by the OneCare Board of Managers in June 2021.

- **05-02 Participant and Preferred Provider Appeals** *(formerly titled "Participant Appeals")*
  - **Purpose:** To outline the guidelines for Participants and Preferred Providers to appeal a determination, decision, or action made or taken by OneCare related to the Participant's or Preferred Provider's participation in any ACO Payer Programs.
  - **Key Changes:** No material updates to the policy; changes were limited to the inclusion of definitions for terms that have historically been in the policy but not defined, and other minor edits for improved clarity.

- **05-03 Network Development and Composition**
  - **Purpose:** To outline the standards by which OneCare will meet key contractual obligations related to development and composition of the OneCare Network.
  - **Key Changes:** No substantive changes; all edits are for the purpose of improved clarity.

Policy Number & Title:	05-02 Participant and Preferred Provider Appeals
Responsible Department:	Contracting
Author:	Martita Giard, Director, ACO Contracting
Original Implementation Date:	July 19, 2016
Revision Effective Date:	June 15, 2021

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

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

III. **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:

Appeals Committee means the ACO's Chief Medical Officer, Chief Operating Officer, Vice President of Finance, and Director of Payment Reform.

Level 1 Appeal means the first written and formal method a Participant or Preferred Provider may invoke to address a determination, decision or action made by the ACO.

Level 2 Voluntary Appeal means the second written and formal method a Participant or Preferred Provider may invoke if the Level 1 Appeal determination was not satisfactory to the Participant or Preferred Provider.

Meeting means a time and method by which the Participant or Preferred Provider is able to discuss the subject of the appeal before the Panel.

Panel means a minimum of at least three (3) members of the Appeals Committee that will hear the second-level appeal.

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

- Calculation of shared savings or loss (risk), distributions, or assessments;
- Calculation of capitated or other alternative fee-for-service program payments;
- Discipline, sanction, or termination of a Participant, Preferred Provider, or Provider from an ACO Program;
- Denial of a request of a Participant or Preferred Provider to participate in an ACO Payer Program;
- Denial of a request by the ACO to share or distribute data concerning a Provider's performance data as it appears unrelated to ACO Activities, or outside of data use policies and procedures set by the ACO; and
- Removal from the ACO.

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

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

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

A. Level 1 Appeal

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

A Level 1 Appeal must include the following information:

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

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

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

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

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

B. Level 2 Voluntary Appeal

A Participant or Preferred Provider may submit a Level 2 Voluntary Appeal in writing no later than ninety (90) calendar days after the date of the ACO's written decision on the Level 1

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

Appeal. The ACO's Appeals Committee ("Committee") will determine whether to grant or deny the Level 2 Voluntary Appeal. Any materials reviewed in conjunction with the Level 1 Appeal will be provided to the Committee for review and consideration in making a determination on this appeal. The Participant or Preferred Provider may also submit additional relevant information or documents to the Appeals Committee for review and consideration. The ACO will provide written acknowledgement of its receipt of the Level 2 Voluntary Appeal within fifteen (15) business days of receiving it.

The Appeals Committee shall consist of the ACO's Chief Medical Officer, Chief Operating Officer, Vice President of Finance, and Director of Payment Reform.[2] The Committee may also designate any member(s) of OneCare's Workforce who may have knowledge or expertise relevant to the subject of the appeal as additional members of the Committee to participate in the review and determination of the appeal. The Appeals Committee may not designate the Director of ACO Contracting as an additional member, however it may request relevant factual information from that individual.

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

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

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

C. Appeal Extension Guidelines

The Participant or Preferred Provider may make a written request for an extension of any timeframe set forth in this Policy. Any such request must include the reason for making the request and a reasonable estimate of the additional time needed. The ACO may, in its sole discretion, grant this request under the following circumstances: (1) the information or documents supporting the appeal are voluminous and/or complex such that additional time is

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

required for review; (2) information or documents in the possession of third parties, or witnesses with relevant factual knowledge of the subject of the appeal, that are necessary for making a reasonable determination to grant or deny the appeal are not available within the prescribed timeframes, but will be available at a reasonable later date; or (3) the ACO and Participant or Preferred Provider, despite good-faith efforts, are unable to schedule the Meeting within the forty-five (45) calendar day window permitted, and the Meeting can be scheduled within a reasonable period of time outside of the window.

D. Effect of Appeal Decisions

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

Submit Appeals to:

OneCare Vermont Accountable Care Organization, LLC
Attn: Director, ACO Contracting
356 Mountain View Drive, Suite 301
Colchester, Vermont 05446

V. Review Process: This Policy will be reviewed annually and in accordance with the terms of OneCare's ACO Program Agreements with Payers.

VI. References:

- OneCare's Policy and Procedure Glossary
- OneCare's Program Agreements with Payers
- State of VT GMCB Rule 5.000: Oversight of Accountable Care Organizations

VII. Related Policies/Procedures:

- 05-03 Network Development and Composition Policy

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

Management Approval:

Martita A. Giard — 06/23/2021
Director, ACO Contracting — Date

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

Board of Managers Approval:

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

Policy Number & Title:	05-03 Network Development and Composition
Responsible Department:	Contracting
Author:	Martita Giard, Director, ACO Contracting
Original Implementation Date:	January 1, 2017
Revision Effective Date:	June 15, 2021

I. **Purpose:** To outline the standards by which OneCare will meet key contractual obligations related to development and composition of the OneCare Network.

II. **Scope:** Applicable to the OneCare Workforce.

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

IV. **Policy:** OneCare will maintain a network of willing Participants, Preferred Providers, and Collaborators who desire to participate with the ACO for engagement in ACO Programs ("OneCare Network").

1. OneCare will contract only with network Participants, Preferred Providers and Collaborators who are in good contractual standing with the respective payer(s) for the ACO Programs in which they participate.

2. OneCare will not discriminate against any contracted network Participant, Preferred Provider or Collaborator who is acting within the scope of his/her license or certification under applicable state laws, solely on the basis of such license or certification.

3. If OneCare declines participation to a health care provider or other organization who requests network participation, it shall inform that provider or organization of that decision in writing. The Participant or Preferred Provider may appeal that determination as permitted by *05-02 Participant & Preferred Provider Appeals Policy.* Providers may seek further clarification of the ACO's decision as outlined in *05-07 Provider Appeal of Denial of Participation in ACO*.

4. OneCare will maintain a contracted network that includes sufficient numbers of facilities, physicians, ancillary providers, continuum of care providers, for the provision of high-quality covered services for Attributed Lives. That contracted network, together with non-contracted providers that Attributed Lives may seek care from, will meet the requirements for an adequate network found in ACO Program Agreements. OneCare does not prevent Attributed Lives from seeking care from providers who are not in the OneCare network.

5. OneCare shall obligate its network Participants, Preferred Providers and Collaborators to adhere to the requirements and/or obligations contained in each ACO Program Agreement in which they participate in.

6. OneCare will not restrict Attributed Lives from accessing care from any provider, in or out of OneCare's network.

V. **Review Process:** This policy will be reviewed annually and in accordance with the terms of OneCare's ACO Program agreements with Payers.

VI. References:

- OneCare's Policy and Procedure Glossary
- ACO Program Agreements
- 42 CFR 438.12

VII. Related Policies/Procedures:

- 05-02 Participant and Preferred Provider Appeals Policy
- 05-07 Provider Appeal of Denial of Participation in ACO

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Management Approval:

Martita A. Giard — 06/23/2021

Director, ACO Contracting — 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