OneCareVermont

**OneCare Vermont Accountable Care Organization, LLC**
**Board of Managers Meeting Agenda**
**December 18, 2018**
**4:30 p.m. – 7:00 p.m.**
**Phone Call Only**

| Time | Agenda Item | Presenter |
|---|---|---|
| 4:30 p.m. | Call to Order | Kevin Stone |
| 4:32 p.m. | Approval of Minutes*<br>• November 13, 2018 Board of Managers Meeting | Kevin Stone |
| 4:35 p.m. | CEO Updates | Todd Moore |
| 4:40 p.m. | OneCare Committee Updates<br>• Executive Committee<br>• Finance Committee*<br>*Vote to Approve October Monthly P&L*<br>• Population Health Strategy Committee*<br>*Vote to Approve New Members Appointments to the Population Health Strategy Committee* | Kevin Stone<br>Todd Keating<br>Steve Leffler |
| 4:50 p.m. | CMO Update* | Norm Ward |
| 4:55 p.m. | YTD Payer Program Summary Performance Update* | Tom Borys |
| 5:00 p.m. | Board Compliance Training* | Greg Daniels |
| 5:15 p.m. | Public Comment | Kevin Stone |
| 5:20 p.m. | OneCare Board of Managers Executive Session | Kevin Stone |
| 7:00 p.m. | Adjourn | Kevin Stone |

*Denotes Attachment

Attachments:

1. Draft of OneCare Board of Manager Minutes from November 13, 2018
2. October Financial P&L Report
3. Population Health Strategy Committee New Membership Bio's
4. CMO's Corner
5. 2018 YTD Payer Program Summary Dashboard Performance Report
6. Compliance Training PowerPoint

***Note: Reasonable expenses of managers for attendance at board meetings may be paid or reimbursed by OneCare Vermont.***

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# ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
## BOARD OF MANAGERS MEETING
## NOVEMBER 13, 2018

## MINUTES

A meeting of the Board of Managers of OneCare Vermont Accountable Care Organization, LLC ("OneCare") was held on November 13, 2018 by phone.

I. Call to Order

Kevin Stone called the meeting to order at 4:34 p.m.

II. Minutes

The minutes from October 16, 2018, were approved unanimously.

III. CEO Update

Todd Moore reminded Board members and committee chairs that details of negotiations are confidential and shouldn't be shared publicly.

Sara Barry shared a success story with the Board focusing on a medically complex patient with 28 health conditions and a pattern of one-week home and then three weeks in the hospital. The patient had been depressed, fearful, exhausted by many inpatient admits and transfers. Their goal was to stay at home but complexity made this challenging, possibly unlikely without strong team coordination. Intensive team-based care coordination began in August and the patient chose a nurse care coordinator from their primary care office as their lead care coordinator (LCC).

The local and referral hospitals collaborated to supply all equipment and surgical supplies that are needed. The LCC worked on coordinating services and prescriptions and addressing the individual's identified barrier of unmanageable out-of-pocket expenses. Multiple care conferences were held by phone and at the patient's home, involving home health, Choices for Care, Nurse Care Coordinators, neighbors, diabetic educator, spouse, pharmacy, etc. LCC organized a team to care for the spouse (also a patient of the practice though unattributed) who was experiencing other social and economic challenges and was asking for help. LCC identified existing social supports and arranged a plan for them to support couple with cooking and caregiving at the home, thus enabling more stable home and emotional support to help keep the patient out of hospital.

Early signs indicate a significant reduction in utilization: now 11+ weeks at home with no inpatient or emergency department admits and managing complexity successfully. The patient has accomplished several of their initial care plan goals and is making progress on several new goals.

IV. Committee Updates

*Executive Committee:* The Committee met by phone the previous week and discussed the presentation to the GMCB by the OneCare leadership team, formation and scheduling of meetings for the Governance Ad-Hoc Committee, and received an update on commercial payer negotiations.

*Finance Committee:* The Finance Committee is not scheduled to meet until the following evening, so there was no update to give. The Committee did endorse, by email vote the September monthly P&L for approval by the full Board. Upon a motion being made and second the September monthly financials were approved.

*Patient and Family Advisory Committee:* The committee met last Thursday, and in compliance with Rule 5, Julia Shaw and Amelia Schlossberg from the Office of the Healthcare Advocate (HCA) attended the meeting. They described the services their office provides to Vermonters, shared brochures with contact information and then asked OneCare staff to leave the room to allow them to speak with the committee members. They also asked Board members who attend the PFAC meetings, Toby Sadkin (Independent Primary Care Provider) and Betsy Davis (Medicare Beneficiary), to also leave the room during this time as well. The Board members expressed that they did not understand why they were asked to leave and that it made them uncomfortable.

After the meeting re-convened without the HCA there was a brief update about the Care Navigator mobile app that has been rolled out and an invitation for committee members to work with Robyn Skiff on refining this app for patient use.

V. CMO Update

Dr. Norman Ward updated the Board on clinical activities that are highlighted in the CMO's Corner document in the public packet. Dr. Ward also expanded on the different phases of implementation of the Skilled Nursing Facility (SNF) Waiver noting the difficulty of phase 2 and 3 (patients going directly from the emergency room or home to the SNF) as this requires validation that the patients' needs are not being met at home and are in need of being in the SNF.

VI. Program Updates:

Tom Borys updated the Board on the Year to Date Payer Program Summary Dashboard Performance that was included in the public packet. Dr. Joe Perras gave feedback that the data provided to the Windsor HSA in regards to performance is helpful in tracking against target as well as analyzing specific utilization and cost patterns of specific procedures.

VII. Public Comment:

There was no public comment.

VIII. Recess

IX. Executive Session

X. Voting

a. The Executive Session Minutes from October 16, 2018 were approved unanimously.

XI. Other Business

There was no other business.

XII. Adjourn

Upon a motion that was seconded, the meeting adjourned at 6:37 p.m.

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**Attendance:**

OneCare Board Members

- ☒ Sierra Lowell
- ☐ Lorne Babb, MD
- ☒ Jill Berry-Bowen
- ☒ John Brumsted, MD
- ☒ Betsy Davis
- ☐ Tim Ford
- ☒ Steven Gordon
- ☐ Todd Keating
- ☒ Steve LeBlanc
- ☐ Steve Leffler, MD
- ☒ Judy Morton
- ☒ Mary Moulton
- ☒ Pamela Parsons
- ☒ Joseph Perras, MD
- ☒ Judy Peterson
- ☒ Toby Sadkin, MD
- ☒ John Sayles
- ☒ Kevin Stone

OneCare Risk Strategy Committee

- ☐ Tom Dee
- ☐ Jeffrey Haddock, MD
- ☐ Tom Manion
- ☐ Anna Noonan

OneCare Leadership and Staff

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

# OneCare Vermont

*Statement of Assets, Liablilities and Equity*
October 31, 2018

| | Current Month | | Previous Month | | Change |
|---|---|---|---|---|---|
| Cash - Unrestricted | 4,168,550 | $ | 4,381,256 | $ | (212,706) |
| GMCB - Required Reserve Funding | 1,100,000 | $ | 1,100,000 | $ | - |
| Additional Reserve Funding (CMS) | 4,138,014 | $ | 4,135,465 | $ | 2,549 |
| VBIF Funding | 3,231,126 | $ | 2,880,900 | $ | 350,226 |
| Advance Funding - VMNG | 4,843,849 | $ | 4,886,738 | $ | (42,889) |
| Network Receivable | 1,420,891 | $ | - | $ | 1,420,891 |
| Accounts Receivable | 2,771,869 | $ | 2,187,244 | $ | 584,624 |
| Prepaid Expense | 1,384,294 | $ | 89,557 | $ | 1,294,737 |
| **Total Assets** | **23,058,593** | **$** | **19,661,161** | **$** | **3,397,432** |
| Unearned Revenue | 2,714,848 | $ | 304,898 | $ | 2,409,950 |
| Accrued Expenses | 312,604 | $ | 379,003 | $ | (66,400) |
| Network Payable | 8,545,210 | $ | 8,278,094 | $ | 267,116 |
| Due to UVMHN - CMS Reserve Funding | 4,124,849 | $ | 4,124,849 | $ | - |
| Due to UVMMC - CY18 | 6,510,244 | $ | 5,722,181 | $ | 788,062 |
| Due to DHH - CY18 | 800,840 | $ | 802,136 | $ | (1,296) |
| **Total Liabilities** | **23,008,593** | **$** | **19,611,161** | **$** | **3,397,432** |
| Capital Contribution UVMMC | 25,000 | $ | 25,000 | $ | - |
| Capital Contribution D-H H | 25,000 | $ | 25,000 | $ | - |
| **Total Equity** | **50,000** | **$** | **50,000** | **$** | **-** |
| **Total Liabilities and Equity** | **23,058,593** | **$** | **19,661,161** | **$** | **3,397,432** |

NOTE: This statement is created for the benefit of the member organizations of OneCare Vermont and is not representative of a GAAP Balance Sheet.

**OneCare Vermont**

*2018 P&L*

October 31, 2018

| | Current Month | OCV YTD Actual | YTD Budget | $ Variance Fav/(Unfav) | % Variance Fav/(Unfav) | Annual Budget | Rise VT YTD Actual | Adk ACO YTD Actual |
|---|---|---|---|---|---|---|---|---|
| VMNG Revenue | $ 243,087 | $ 2,606,455 | $ 2,611,960 | $ (5,505) | -0.2% | $ 3,134,352 | $ - | $ - |
| VMNG PHM Program Pilot - Complex CC | $ 28,181 | $ 2,185,773 | $ 2,483,371 | $ (297,598) | -12.0% | $ 2,980,045 | $ - | $ - |
| BCBSVT Reform Pilot Support | $ 59,859 | $ 626,571 | $ 833,333 | $ (206,763) | -24.8% | $ 1,000,000 | $ - | $ - |
| Self-Funded Pilot Revenue | $ 81,684 | $ 590,319 | $ 896,580 | $ (306,261) | -34.2% | $ 1,075,896 | $ - | $ - |
| CMS Medicare Blueprint Replacement | $ - | $ 5,832,570 | $ 6,468,750 | $ (636,180) | -9.8% | $ 7,762,500 | $ - | $ - |
| SOV PHM Program Pilot - Primary Prevention | $ - | $ - | $ 1,250,000 | $ (1,250,000) | -100.0% | $ 1,500,000 | $ - | $ - |
| Informatics Infrastructure Support | $ 291,667 | $ 2,916,667 | $ 2,916,667 | $ 0 | 0.0% | $ 3,500,000 | $ - | $ - |
| Other Grants/Contracts - RWJ | $ - | $ - | $ 43,209 | $ (43,209) | -100.0% | $ 51,851 | $ - | $ - |
| Other Grants/Contracts - Adirondack | $ 18,000 | $ 180,000 | $ 180,000 | $ - | 0.0% | $ 216,000 | $ - | $ - |
| Other Grants/Contracts - Cigna | $ 11,607 | $ 116,073 | $ 86,667 | $ 29,407 | 33.9% | $ 104,000 | $ - | $ - |
| Other Revenue | $ 76,180 | $ 114,507 | $ - | $ 114,507 | 0.0% | $ - | $ 334,863 | $ 707,610 |
| Participation Fees | $ 1,449,945 | $ 14,499,447 | $ 15,382,559 | $ (883,112) | -5.7% | $ 18,459,071 | $ - | $ - |
| **Total Income** | **$ 2,260,209** | **$ 29,668,381** | **$ 33,153,096** | **$ (3,484,715)** | **-10.5%** | **$ 39,783,715** | **$ 334,863** | **$ 707,610** |
| Basic OCV PMPM | $ 331,601 | $ 3,358,654 | $ 3,984,175 | $ 625,521 | 15.7% | $ 4,781,010 | $ - | $ - |
| Care Coordination | $ 454,413 | $ 4,695,322 | $ 5,887,268 | $ 1,191,947 | 20.2% | $ 7,064,722 | $ - | $ - |
| PCP Comprehesive Payment Reform Pilot | $ 57,242 | $ 595,809 | $ 1,500,000 | $ 904,191 | 60.3% | $ 1,800,000 | $ - | $ - |
| VBIF | $ 345,936 | $ 3,615,923 | $ 3,587,686 | $ (28,237) | -0.8% | $ 4,305,223 | $ - | $ - |
| Community Program Investments | $ 27,762 | $ 564,338 | $ 1,314,667 | $ 750,328 | 57.1% | $ 1,577,600 | $ - | $ - |
| Blueprint | $ - | $ 5,835,387 | $ 6,468,750 | $ 633,363 | 9.8% | $ 7,762,500 | $ - | $ - |
| | | | $ - | | | | | |
| Salaries/Fringe | $ 609,099 | $ 5,344,798 | $ 5,486,660 | $ 141,862 | 2.6% | $ 6,583,992 | $ 220,883 | $ 630,942 |
| Purchased Services | $ 211,215 | $ 923,970 | $ 704,805 | $ (219,165) | -31.1% | $ 845,766 | $ 11,895 | $ - |
| Contract & Maintenance | $ 202,554 | $ 2,628,380 | $ 2,437,889 | $ (190,491) | -7.8% | $ 2,925,467 | $ - | $ - |
| Lease & Rental | $ 24,473 | $ 195,515 | $ 267,543 | $ 72,027 | 26.9% | $ 321,051 | $ - | $ - |
| Utilities | $ 3,493 | $ 61,954 | $ - | $ (61,954) | 0.0% | $ - | $ 2,078 | $ - |
| Other Expenses | $ 19,233 | $ 171,381 | $ 1,513,653 | $ 1,342,272 | 88.7% | $ 1,816,384 | $ 100,008 | $ 76,668 |
| **Total Expenses** | **$ 2,287,022** | **$ 27,991,432** | **$ 33,153,096** | **$ 5,161,664** | **15.6%** | **$ 39,783,715** | **$ 334,863** | **$ 707,610** |
| **Net Income / (Loss)** | **$ (26,812)** | **$ 1,676,949** | **$ -** | **$ 1,676,949** | | **$ -** | **$ -** | **$ -** |

## Breena Holmes, M.D.

Breena Welch Holmes, MD is the Director of Maternal and Child Health for Vermont. After finishing her pediatric residency at Seattle Children's Hospital and a chief resident year at University of Massachusetts Medical School, she had a pediatric practice in Middlebury, Vermont, focusing on adolescent health from 1997-2008. In 2008, Breena left her clinical practice to teach Health Literacy and Decision Making at Middlebury Union High School. In 2010, Breena became director of the Maternal and Child Health division which includes the statewide WIC program, School Health, Child Development Clinic, Children with Special Health Needs as well as Family Planning, Domestic and Sexual Violence Prevention, Injury Prevention and Early Childhood systems work including federally funded nurse home visiting and the Help Me Grow system for optimal child development.

Dr. Holmes is the immediate past chair of the Council on School Health for the American Academy of Pediatrics, and on the pediatric faculty at University of Vermont College of Medicine

## Jennifer Gilwee, M.D.

Jennifer Gilwee is a graduate of UVM Undergraduate and Medical School. She did her general Internal Medicine Residency at Brown University/Rhode Island Hospital with a focus on primary care, and graduated in 2000. Jennifer returned to Vermont in the summer of 2000 and began working at UVM in General Internal Medicine.

Jennifer has been heavily involved in all aspects of primary care including various administrative roles, Medical home establishment through Blueprint, and transforming primary care at UVM.

Jennifer is currently the Division Chief of General Internal Medicine and Geriatrics at UVM. In addition to clinical work and administrative duties, Jennifer has also served on the UVMMG faculty practice board for the last 7 years, and a member of the clinical care and

operations committee for the last 5 years. Jennifer also previously served on the board of Vermont Managed Care.

Jennifer is married with two daughters who are athletes so in her spare time she is a soccer and basketball mom.

**Jane Catton, MHA, MSOL**

As a native of Canada, Ms. Catton moved to Vermont in 1992 and brings over 30 years of health care and administrative experience to her new position. She holds a Bachelor of Science in Nursing degree as well as two Master's degrees; one in Health Care Administration and one in Organizational Leadership. She is a Board Certified Nurse Executive and holds additional certification in Health Care Quality.

Ms. Catton's previous work experience has included senior leadership positions in health care in both Canada and United States. She has worked in a variety of hospital, academic and community based health care settings, both as a registered nurse in Critical Care and Oncology, and as an administrative leader. She most recently served as Senior Vice President, Chief Operating Officer and Chief Nursing Officer at Northwestern Medical Center in St. Albans Vermont where she held progressive leadership roles over the span of 13 years.

Ms. Catton has been active in supporting local health care partnerships and organizations, including advancing health reform initiatives through the Accountable Care Organization (ACO) within her local Health Service Area. She is passionate about opportunities to build collaborations that support primary community based care models, through transitions of care and coordination systems, which support our population health goals for our communities.

Ms. Catton lives in St. Albans with her husband and three dogs. She enjoys traveling, and spending time with their five children; two who live overseas and three who are completing their college educations at the University of Vermont in Burlington VT.

**Leah Costello, M.D., F.A.A.P.**

Dr. Leah Costello grew up in South Burlington and received her undergraduate degree at Bates College in Maine. She attended the University Of Vermont College Of Medicine and then moved to Salt Lake City, Utah for her pediatrics residency at the University of Utah. Upon completing her residency, she spent four years as a general pediatrician in Salt Lake City. After the birth of their first child, she and her husband decided to return to Vermont to be near family and raise their children in this beautiful state. Before joining Timber Lane Pediatrics in the fall of 2016, Dr. Costello worked as a hospitalist at University of Vermont Children's Hospital. Dr. Costello enjoys caring for all children of all ages and has a particular interest in early childhood development, adolescent health care and quality improvement. She and her husband, who is a photographer, enjoy spending time with their son and daughter, alpine skiing, mountain biking, traveling and cooking for family and friends.

# PY2018 Target to Actual Performance Dashboard

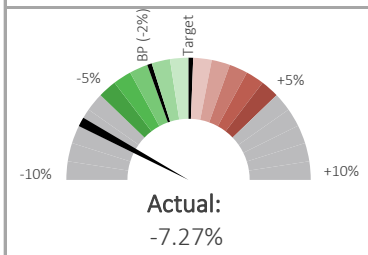
OneCare Vermont Total

**Reporting Period:** Thru July 2018

Medicare claims paid through: 10/26/18
Medicaid claims paid through: 10/26/18
BCBS QHP claims paid through: 10/31/18

## Medicare *(36,230 active members)*

### Risk Settlement Status




| | |
|---|---|
| 256,213 | Member Months (YTD) |
| $872 | Target Cost PMPM[1] |
| $809 | Actual Cost PMPM |
| $223,539,834 | Target Cost[1] |
| $207,286,625 | Actual Cost (FFS Equiv.) |
| $16,253,209 | Under (Gross) |
| **$8,941,593** | **Shared Savings[2]** |

### FFS Equivalent PMPM Target to Actual

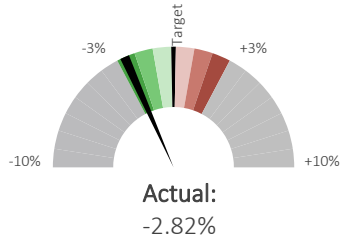
| | Target | Actual | Variance | |
|---|---|---|---|---|
| Inpatient | $ 259.05 | $ 242.86 | ($16.19) | -6% |
| Outpatient | $ 262.35 | $ 228.69 | ($33.66) | -13% |
| Professional | $ 154.24 | $ 131.26 | ($22.99) | -15% |
| DME | $ 14.74 | $ 12.30 | ($2.44) | -17% |
| PAC | $ 103.60 | $ 117.54 | $13.95 | 13% |
| Confidential | $ 60.83 | $ 60.83 | $0.00 | 0% |
| **Total (Gross)** | **$ 854.80** | **$ 793.48** | **($61.32)** | **-7%** |

### Utilization PKPY Target to Actual

| | Target | Actual | Variance | |
|---|---|---|---|---|
| Inpatient | 180 | 214 | 34 | 19% |
| Outpatient | 31,762 | 32,889 | 1,127 | 4% |
| Professional | 19,526 | 20,173 | 647 | 3% |
| DME | 1,474 | 1,478 | 4 | 0% |
| PAC | 2,437 | 3,463 | 1,026 | 42% |
| Confidential | N/A | N/A | N/A | N/A |
| **Total (Gross)** | **N/A** | **N/A** | **N/A** | **N/A** |

## Medicaid *(39,033 active members)*

### Risk Settlement Status




| | |
|---|---|
| 286,799 | Member Months (YTD) |
| $248 | Target Cost PMPM |
| $241 | Actual Cost PMPM |
| $70,991,475 | Target Cost |
| $68,992,321 | Actual Cost |
| **$1,999,154** | **Shared Savings[3]** |
| *$5,989,597* | *FPP Savings [4]* |

### FFS Equivalent PMPM Target to Actual

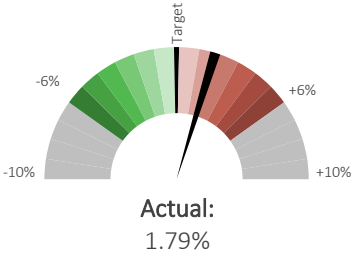
| | Target | Actual | Variance | |
|---|---|---|---|---|
| Inpatient | $ 50.09 | $ 47.69 | ($2.40) | -5% |
| Outpatient | $ 73.08 | $ 59.98 | ($13.09) | -18% |
| Professional | $ 89.99 | $ 85.40 | ($4.59) | -5% |
| DME | $ 6.52 | $ 5.24 | ($1.28) | -20% |
| PAC | $ 3.40 | $ 3.67 | $0.26 | 8% |
| Confidential | $ 24.45 | $ 19.26 | ($5.19) | -21% |
| **Total (Gross)** | **$ 247.53** | **$ 221.25** | **($26.28)** | **-11%** |

### Utilization PKPY Target to Actual

| | Target | Actual | Variance | |
|---|---|---|---|---|
| Inpatient | 48 | 50 | 2 | 3% |
| Outpatient | 6,022 | 4,088 | (1,934) | -32% |
| Professional | 12,350 | 12,530 | 180 | 1% |
| DME | 322 | 352 | 31 | 10% |
| PAC | 325 | 351 | 26 | 8% |
| Confidential | N/A | N/A | N/A | N/A |
| **Total (Gross)** | **N/A** | **N/A** | **N/A** | **N/A** |

## BCBS QHP *(18,695 active members)*

### Risk Settlement Status




| | |
|---|---|
| 137,433 | Member Months (YTD) |
| $500 | Target Cost PMPM |
| $509 | Actual Cost PMPM |
| $68,686,405 | Target Cost |
| $69,918,416 | Actual Cost |
| ($1,232,010) | Over Target (Gross) |
| **($511,284)** | **Losses[5]** |

### FFS Equivalent PMPM Target to Actual

| | Target | Actual | Variance | |
|---|---|---|---|---|
| Inpatient | $ 96.39 | $ 66.31 | ($30.09) | -31% |
| Outpatient | $ 183.26 | $ 216.19 | $32.94 | 18% |
| Professional | $ 131.24 | $ 134.63 | $3.39 | 3% |
| DME | $ 5.45 | $ 5.76 | $0.32 | 6% |
| Community | $ 1.07 | $ 1.98 | $0.91 | 85% |
| Confidential | $ 82.38 | $ 83.91 | $1.53 | 2% |
| **Total (Gross)** | **$ 499.78** | **$ 508.79** | **$9.00** | **2%** |

### Utilization PKPY Target to Actual

| | Target | Actual | Variance | |
|---|---|---|---|---|
| Inpatient | 51 | 24 | (27) | -52% |
| Outpatient | 3,405 | 3,546 | 141 | 4% |
| Professional | 9,491 | 9,813 | 321 | 3% |
| DME | 230 | 248 | 18 | 8% |
| Community | 61 | 87 | 26 | 42% |
| Confidential | N/A | N/A | N/A | N/A |
| **Total (Gross)** | **N/A** | **N/A** | **N/A** | **N/A** |

**Footnotes:**

[1] Includes Blueprint payment of $3,881,250 ($18 PMPM) which accounts for 2% of Medicare Total Cost of Care
[2] Represents shared savings/losses taking into consideration the risk corridor and 80% share for Medicare
[3] Represents shared savings/losses taking into consideration the risk corridor
[4] FPP (Fixed Prospective Payment) Savings are not part of the cash settlement for Medicaid
[5] Represents shared savings/losses taking into consideration the risk corridor, paid to allowed ratio and 50% share for BCBS QHP

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# ACO Board of Managers Annual Compliance Training

*2018*

# Introduction

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- ACOs are required to have a Compliance Program and to conduct compliance training. A Compliance Program helps an organization abide by all applicable rules and standards, and to discover and correct any practices that do not.

- OneCare's Compliance Program includes training, monitoring of regulatory issues, and a system to report compliance concerns. OneCare employees, Participants and Affiliates have an affirmative duty to report any violations of applicable law or policy.

- If you have any compliance concerns related to OneCare or your organization's participation in the ACO, please report them to the OneCare Compliance Officer: Gregory Daniels – Gregory.Daniels@OneCarevt.org

# Presentation Roadmap

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1. **The 7 Pillars of an Effective Healthcare Compliance Program -** according to the OIG
2. **Board Oversight of Compliance Program**
3. **The 4 Main Areas of Healthcare Compliance**
4. **Stark Law/Anti-Kickback Statute**
5. **HIPAA/Privacy and Security**
6. **Conflicts of Interest**
7. **False Claims Act**
8. **ACO Risk Area's**
9. **The 5 Questions** – How to determine when to involve Compliance

# The 7 Pillars of an Effective Compliance Program

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1. **Standards and Procedures** – *The organization shall establish standards and procedures to prevent and detect criminal conduct.*
2. **High-Level Responsibility** – *Responsibility for oversight of the compliance program be assigned to specific high-level personnel of the organization.*
3. **Employee Screening –** *The organization has an obligation to conduct background checks on new employees who exercise "substantial authority."*
4. **Education and Training** – *Education must be provided to members of the governing authority, high-level personnel, substantial authority personnel, employees, and agents.*

# The 7 Pillars of an Effective Compliance Program – cont.'d

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5. **Monitoring and Auditing** (including reporting) – *The organization must establish and communicate to employees their right an obligation to report suspected violations of law to appropriate individuals without fear of retribution or adverse consequences.*
6. **Enforcement and Discipline** – *The organization must adopt mechanisms to ensure that employees whose activities violate compliance standards, or Medicare or Medicaid program rules and regulations, are punished.*
7. **Response and Prevention** – *After receiving a complaint of, or learning of, evidence of compliance violations, the organization must demonstrate it has responded appropriately to the situation, including taking steps necessary to prevent further similar offenses.*

"The Seven Elements of a compliance program are important individually, but are most effective on an interdependent basis." CMS

# Expectations for Board Oversight of Compliance Program Functions:

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- Board Members have a fiduciary obligation to OneCare VT when acting on its behalf.
- A Board 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, *cont.*

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

1. The Federal Sentencing Guidelines (Guidelines),
2. OIG's voluntary compliance program guidance documents, and
3. OIG Corporate Integrity Agreements (CIAs) – 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, *cont.*

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- Boards are expected to put forth a meaningful effort to review the adequacy of existing compliance systems and functions within the organization.
- Boards should develop a formal plan to stay abreast of the regulatory landscape and operating environment, including periodic updates from informed staff or review of regulatory resources made available to them by staff.
- Board members are generally entitled to rely on the advice of experts in fulfilling their duties.
- The Board should have a process to ensure appropriate access to information.

# Board Oversight, *cont.*

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The Board of a Next Generation ACO plays a key role in meeting the requirements for the use of ACO Fraud and Abuse Waivers for certain arrangements, including:

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

# 4 Main Areas of Healthcare Compliance

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1. **Stark Law/Anti-Kickback Statute**
2. **HIPAA/Privacy and Security**
3. **Conflicts of Interest** (including medically and necessary services, etc.)
4. **False Claims** (including coding, reimbursement, billing, etc.)

For NextGen ACOs like OneCare VT, program waivers - such as Benefits, Fraud and Abuse, and Participation Waivers - provide broad protections from liability for participants in the ACO Network, as well as some others.

# Financial Relationships/Kickbacks/Inducements

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Other laws prevent fraud, waste and abuse and apply to “kickbacks” or “inducements” exchanged between providers or given to patients.

- These laws prohibit knowingly giving or taking anything of value in order to obtain patient referrals, or other business, that is payable under a federal health program like Medicare and Medicaid. Additional laws prevent physicians from having a financial relationship with an entity to which they refer beneficiaries, unless certain standards are met.

- The ACO must agree, and must require its ACO participants to agree, to comply with all applicable laws including, but not limited to the False Claims Act, the anti-kickback statute, and the physician self-referral law.

# Financial Relationships/Kickbacks/Inducements

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Examples of activities that would violate these laws are:

- An ACO giving its participating providers payments to direct referrals to an ACO hospital.
- A laboratory providing a computer or other equipment to a physician's office to obtain their lab business.
- An ACO Participant waiving co-payments or deductibles, or giving out gift cards, to encourage beneficiaries to obtain care within the ACO.
- A hospital giving extra funding or free office space to private physicians to ensure that they refer beneficiaries to the hospital.
- A medical device vendor giving gifts to a health care provider to boost sales of its products.

# Permitted Activities

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There are also some exceptions to these laws.

- A practice may waive a beneficiary's co-payment or deductible if it determines that the beneficiary has financial need.
- A vendor may offer a standard discount or rebate to a health care provider.
- An ACO may also provide certain preventive care items or services to beneficiaries to help them meet clinical goals.

The rules can be complicated, so if you have questions about financial relationships among health care providers, beneficiaries, and/or vendors, ask your legal advisor or compliance officer.

# Risk Area: Privacy, Security and Confidentiality

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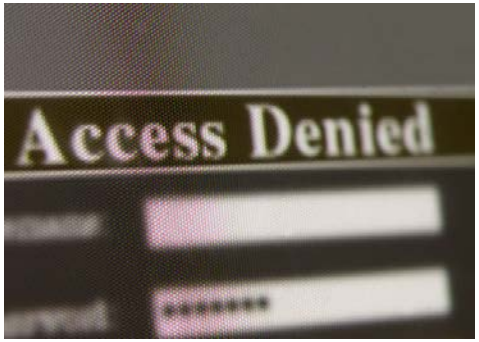
As a Business Associate, OneCare must comply with all of the privacy and security rules that apply to HIPAA covered entities, and must abide by its business associate agreements with Participants. Among other things, this means:

- Minimum Necessary: OneCare must make reasonable efforts to use and disclose only the minimum amount of protected health information necessary to accomplish the intended purpose of the use or disclosure.
- Notice of Breach: OneCare must cooperate with its participating providers to provide notice of any breach of confidentiality. If you suspect that protected health information has been inappropriately accessed, used or disclosed, notify the Security Officer immediately.
- Role Based Access: OneCare and its Participants grant role-based system access to workforce members; access must be limited to only those individuals that require such access to carry out their job duties. If a workforce member has a change to his or her job duties, including a termination of employment, notify the Security Officer immediately so that access may be modified or terminated.



# Risk Area: Privacy, Security and Confidentiality

OneCareVermont

- Beneficiary personal information must be treated confidentially. Under federal law (referred to as "HIPAA") a provider may use or disclose identifiable patient information only upon a patient's signed authorization, or if it is necessary for:
  - >Treatment of the patient
  - >Payment for services
  - >The regular business or operations of the provider

- Beneficiaries may decline to allow payers to share their claims data with OneCare. OneCare must not request data on a beneficiary who has "opted out" of data sharing. If a beneficiary notifies you that he or she chooses to opt-out, you must promptly inform OneCare.

# Privacy, Security and Confidentiality

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- Generally, beneficiary data should not be shared outside of the ACO. If you are communicating with individuals or entities that are not ACO Participants (such as government officials, associations or advocacy groups, etc.) you should refer to the OneCare Privacy and Security Policy and the Data Use Policy, available on the OneCare portal. You may also need to contact the OneCare Compliance Officer or Information Security Officer.

# Risk Area: Privacy, Security and Confidentiality

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## OneCare's Data Use Policy

- Data may be used and disclosed only for accountable care activities
- The minimum necessary rule always applies
- Access to data and systems needs to be role-based
- Aggregate data (without patient identifiers) generally may be shared broadly
- Special Considerations:
  - "PHI" or personally identifiable protected health information: May only be shared with OCV workforce, Board of Managers, Participants, Regional Clinical Representatives and others who have signed agreements with OneCare.
  - "Commercial Proprietary Data/Claims Data" – commercial payer information related to payments, rates or other payer financial information. *May not be shared with other Participants, Collaborators, Regional Clinician Representatives or Regional Performance Committee.*
- If unsure, consult Legal or Compliance!

# Conflicts of Interest

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Conflicts of Interest are those circumstances in which the personal interests of a Board Member(s), Manager(s), Officer(s), or Key Employee(s) of an ACO may potentially or actually conflict with the interests of the ACO, or may be perceived as potentially conflicting with the interests of the ACO. Personal interests include not only this person's own interests but also include those of the person's family member.

# Conflicts of Interest

OneCareVermont

Examples of Conflicts of Interest:

- Relationship with outside entities
- Gifts and Gratuities
- Inside Information
- Financial Interests
- Non-Financial Interests
- Outside Activities
- Corporate Opportunity

# The False Claims Act

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- The government enforces the False Claims Act to guard against misconduct in state and federal health care programs. The False Claims Act applies to any request for payment where the government provides any portion of the money . The law prohibits any person:
  - From knowingly presenting a false (or fraudulent) claim or conspiring to get a false claim paid;
  - From submitting a false record or statement to get a false claim paid; or
  - From knowingly keeping an overpayment.

New Hampshire and Vermont state laws also prohibit filing false or fraudulent claims.

# The False Claims Act

OneCareVermont

All personnel involved in the collection and reporting of quality and other data must ensure that the data is complete and accurate. Representatives of OneCare are required to attest to the accuracy of data submissions.

Annual certification. At the end of each performance year, an individual with the legal authority to bind the ACO must certify to the best of his or her knowledge, information, and belief—

- (i) That the ACO, its ACO participants, its ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities are in compliance with program requirements; and

- (ii) The accuracy, completeness, and truthfulness of all data and information that are generated or submitted by the ACO, ACO participants, ACO providers/suppliers, or other individuals or entities performing functions or services related to ACO activities, including any quality data or other information or data relied upon by CMS in determining the ACO's eligibility for, and the amount of a shared savings payment or the amount of shared losses or other monies owed to CMS.

# The False Claims Act

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For ACOs, False Claims liability could arise from:

- Incorrect quality or other data submitted
- False certifications of compliance or application information
- Failure to return identified overpayments

## Does an ACO submit "claims"?

OneCare submits certifications and reports to government programs to obtain payment. It also submits large amounts of data to support the certifications. These submissions are akin to a provider's fee-for-service claims, and the State and Federal False Claims Acts apply to them. They must supported by auditable records.

# The False Claims Act

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Some points to remember about the False Claims Act:

- False claims can result from something other than an intent to break the law. False claims may arise from repeated errors that reflect “deliberate ignorance” or “reckless disregard” of the rules.

- False Claims laws allow individuals to act as “whistleblowers” and sue anyone they believe has defrauded the government. The government may join the suit if they believe the whistleblower has a good case. If the case is won, the whistleblower is entitled to a portion of the money recovered.

- Penalties under False Claims laws are severe, and can include fines of millions of dollars as well as exclusion from government health care programs.

- There are protections under both state and federal law for whistleblowers. They may not be retaliated against for reporting improper conduct or participating in an investigation.

# ACO Risk Areas

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

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

The ACO-specific risk areas are described in the following slides.

# ACO Risk Areas

OneCareVermont

- ACOs have certain requirements built into their Participation Agreements with CMS.
- These requirements give rise to specific areas of risk, including:
  - Diagnosis Coding
  - Stinting on Care or Overutilization
  - Avoiding Certain Beneficiaries
  - Beneficiary Outreach and Marketing
  - Patient Choice
  - Patient Inducements

# Risk Area: Diagnosis Coding

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- Accurate diagnosis coding is important for proper beneficiary risk adjustment and payment methodologies.
- The medical record must include provider documentation to support the assignment of a diagnosis code on a claim.
- A diagnosis should be assigned only for conditions that the provider:
  - > Monitored
  - > Evaluated
  - > Assessed or
  - > Treated

  during that encounter. A diagnosis should not be reported if it has resolved or is no longer being treated. History codes, however, may be reported when relevant.

# Risk Area: Stinting on Care or Over-utilization

OneCareVermont

Because ACO Programs reward lower provider expenditures, ACO Providers must ensure that they are not providing reduced care to ACO beneficiaries, to improperly 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: Avoiding Certain Beneficiaries

OneCareVermont

ACO Providers may not avoid beneficiaries with high medical needs, or "at-risk" beneficiaries. An "at-risk" beneficiary includes a patient who:

- has one or more chronic conditions;
- is dually eligible for Medicare and Medicaid;
- is diagnosed with a mental health or substance abuse disorder, or has had a recent diagnosis that is expected to result in increased cost;
- has had two or more hospitalizations or emergency room visits each year, or otherwise has a high utilization pattern.

# Risk Area: Beneficiary Outreach and Marketing

OneCareVermont

In order to prevent ACOs from seeking to attract or avoid beneficiaries with certain health profiles, and to guard against beneficiary confusion, an ACO's communications with beneficiaries is regulated.

- Medicare Providers must notify beneficiaries that they are participating in an ACO. This includes posting a notice in their office. Providers of primary care services must keep records of providing the notice. OneCare can provide recommendations regarding how to implement this notification and record-keeping process.

- Beneficiary educational materials specific to participation in the ACO must be submitted for approval before being distributed. In some cases the ACO must use specific templates and language.

Please submit marketing-related materials to OneCare for review. If you have questions regarding marketing or any beneficiary communications, please contact OneCare at:

onecarevt@onecarevt.org or (802) 847-7220 option 3

# Risk Area:  Patient Choice

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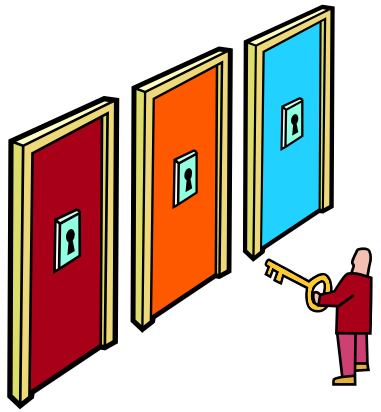
Patients assigned to an ACO have full freedom of choice in selecting providers. Beneficiaries may choose providers outside of the ACO with no penalty.

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



# Risk Area: Inducements to Patients

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- ACOs may not offer or provide gifts or other inducements to a beneficiary to encourage them to receive services from the ACO or any of its participants.

- An ACO and its participants may, however, provide items or services related to the beneficiary's medical care that are either preventive in nature or help the beneficiary achieve a clinical goal. For example, a practice may provide a patient with a blood pressure monitor to better control hypertension.

- The ACO is required to maintain the records for each in-kind item or service provided. 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.

# 5 Questions to Ask Yourself When Deciding Whether to Consult Compliance

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1. Does the "thing" (new idea, new process, new technology, etc.) require an exchange of anything of value with a physician, patient, or other referral source?
2. Does it change the way services are documented, coded, or reimbursed?
3. Are there any possible improper motives or conflicts – either real or perceived - to consider in doing the thing? Particularly of interest are conflicts related to clinical decision-making.
4. Does it require sharing protected health information (PHI), or business confidential information, outside of OneCare VT?
5. Does it require evaluation by any other experts in the organization? e.g. legal, HR, revenue cycle, etc.

- Helpful threshold for asking these questions: When considering anything that's new such as a new process, a new technology, material update of an existing process, etc.
- Also helpful for Compliance staff to ask these questions as part of any discreet review request, e.g. privacy review.

# Speak Up about Compliance Concerns

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OneCare personnel have a duty to report any possible misconduct or violation of law. If you have a compliance concern, you should:

- Inform your supervisor or manager, or
- Report your concern directly to the Compliance or Security Officer, or
- Report the concern through the Compliance Hotline, which you may do anonymously.

Important: Reports remain confidential and retaliation for reporting is prohibited.

Compliance Officer: Gregory Daniels (802) 847-3164

Security Officer : Heather Roszkowski (802) 847- 8291

Telephone Hotline:

802- 847-7220 or Toll-free 877-644-7176

Select Option 3

Or email: OneCareVTHotline@OneCareVermont.org

# Document your training

OneCareVermont

If you have any questions regarding the Attestation, please contact OneCare or the Compliance Officer.

- OneCare : (877)-644-7176 option 1 or onecarevt@onecarevt.org
- Compliance Officer: Gregory Daniels (802) 847-3164

Thank you for reviewing this ACO Compliance training.

**Because OneCare must keep records of training completion, please click the link below and complete the survey and training assessment.**

https://www.surveymonkey.com/r/2018OCVCompliance.