



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**

<u>Time</u>	<u>Agenda Item</u>	<u>Presenter</u>
4:30 p.m.	Call to Order	Kevin Stone
4:32 p.m.	Approval of Minutes* <ul style="list-style-type: none">November 13, 2018 Board of Managers Meeting	Kevin Stone
4:35 p.m.	CEO Updates	Todd Moore
4:40 p.m.	OneCare Committee Updates <ul style="list-style-type: none">Executive CommitteeFinance Committee* <i>Vote to Approve October Monthly P&L</i>Population Health Strategy Committee* <i>Vote to Approve New Members Appointments to the Population Health Strategy Committee</i>	Kevin Stone Todd Keating 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.

DRAFT FOR APPROVAL



Attendance:

OneCare Board Members

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> Sierra Lowell | <input checked="" type="checkbox"/> Steven Gordon | <input checked="" type="checkbox"/> Joseph Perras, MD |
| <input type="checkbox"/> Lorne Babb, MD | <input type="checkbox"/> Todd Keating | <input checked="" type="checkbox"/> Judy Peterson |
| <input checked="" type="checkbox"/> Jill Berry-Bowen | <input checked="" type="checkbox"/> Steve LeBlanc | <input checked="" type="checkbox"/> Toby Sadkin, MD |
| <input checked="" type="checkbox"/> John Brumsted, MD | <input type="checkbox"/> Steve Leffler, MD | <input checked="" type="checkbox"/> John Sayles |
| <input checked="" type="checkbox"/> Betsy Davis | <input checked="" type="checkbox"/> Judy Morton | <input checked="" type="checkbox"/> Kevin Stone |
| <input type="checkbox"/> Tim Ford | <input checked="" type="checkbox"/> Mary Moulton | |
| | <input checked="" type="checkbox"/> Pamela Parsons | |

OneCare Risk Strategy Committee

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Tom Dee | <input type="checkbox"/> Tom Manion |
| <input type="checkbox"/> Jeffrey Haddock, MD | <input type="checkbox"/> Anna Noonan |

OneCare Leadership and Staff

- | | | |
|---|---|--|
| <input checked="" type="checkbox"/> Todd Moore | <input checked="" type="checkbox"/> Tom Borys | <input checked="" type="checkbox"/> Linda Cohen Esq. |
| <input checked="" type="checkbox"/> Vicki Loner | <input checked="" type="checkbox"/> Sara Barry | <input checked="" type="checkbox"/> Spenser Wepler |
| <input checked="" type="checkbox"/> Karen Lee | <input type="checkbox"/> Susan Shane | <input checked="" type="checkbox"/> Amy Bodette |
| <input checked="" type="checkbox"/> Norm Ward, MD | <input type="checkbox"/> Joan Zipko | |
| <input checked="" type="checkbox"/> Greg Daniels | <input checked="" type="checkbox"/> Martita Giard | |

OneCare Vermont

Statement of Assets, Liabilities 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 UVMHC - 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 UVMHC	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 Comprehensive 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	
<p>Actual: -7.27%</p>	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 Savings²

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	
<p>Actual: -2.82%</p>	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 Savings³
	\$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	
<p>Actual: 1.79%</p>	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) Losses⁵

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:

¹Includes Blueprint payment of \$3,881,250 (\$18 PMPM) which accounts for 2% of Medicare Total Cost of Care

²Represents shared savings/losses taking into consideration the risk corridor and 80% share for Medicare

³Represents shared savings/losses taking into consideration the risk corridor

⁴FPP (Fixed Prospective Payment) Savings are not part of the cash settlement for Medicaid

⁵Represents 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.



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.



- 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.



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

- 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



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.

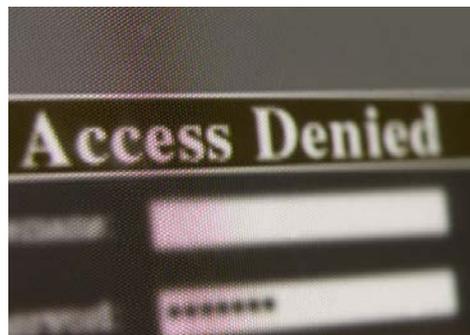
Risk Area: Privacy, Security and Confidentiality



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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



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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



- 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



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



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



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



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- 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



- 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



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



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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



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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

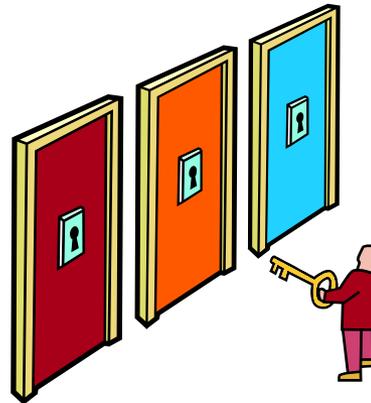


Risk Area: Patient Choice



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



- 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



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



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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.](https://www.surveymonkey.com/r/2018OCVCompliance)



OneCareVermont

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
BOARD OF MANAGERS MEETING
DECEMBER 18, 2018

MINUTES

A meeting of the Board of Managers of OneCare Vermont Accountable Care Organization, LLC (“OneCare”) was held by phone on December 18, 2018.

I. Call to Order

Kevin Stone called the meeting to order at 4:36 p.m.

II. Minutes

The minutes from November 13, 2018 were approved unanimously.

III. CEO Update

Mr. Moore reminded the Board of the sensitivity around contract negotiations and that details of those discussions are confidential.

IV. Committee Updates

Executive Committee: The Committee discussed the recommendations of the Governance Ad-Hoc Committee which will be discussed in executive session. Mr. Stone thanked the Governance Ad-Hoc Committee for their work. The Committee also reviewed the Green Mountain Care Board budget review and approval process. Mr. Stone notified the Board that Lorne Babb and Tim Ford had both resigned their seats from the Board and thanked them for their service. The nomination process is near final and the vacant seats will be filled by February.

Finance Committee: The Finance Committee discussed the continued uncertainty of the Medicare rates and calculations. The committee was also updated on commercial payer negotiations and the 2019 Vermont Medicaid Next Generation final negotiations and financial model. The November financials were also endorsed for Board Approval. Upon a motion being made and seconded the October monthly financials were approved.

Population Health Strategy Committee: The committee met and endorsed the addition of four new members to the Population Health Strategy Committee: Dr. Breena Holmes, Jane Catton, Dr. Leah Costello, and Dr. Jennifer Gilwee. Upon a motion that was made and seconded, the four nominees to the population health strategy committee were approved unanimously by the Board. Additional topics of discussion included the Specialty Payment Reform Pilot and the Innovation Fund. The Innovation Fund RFP will be released later this week.



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. The Clinical and Quality Advisory Committee had a presentation given by Sally Craft on Population Health initiatives at Dartmouth Hitchcock. There was also a progress update on the Medicare benefit enhancement waivers. The Pediatrics subcommittee had a presentation on asthma triggers and there was discussion around creating continuity of care for children in the custody of Department of Children and Family Services. The Patient and Family Centered Care Grand Rounds was held recently and was well attended.

VI. Program Updates:

Tom Borys updated the Board on the Year to Date Payer Program Summary Dashboard which has a new layout (included in the public packet). The new layout is designed to improve readability.

VII. Compliance:

Greg Daniels conducted the annual compliance training for the Board. Mr. Daniels highlighted the seven pillars of a compliance program, as well as reminding the Board members of their compliance obligations. See Slide deck provided in the public packet. It was noted that because OneCare is a provider led ACO, that conflict of interest can cause confusion. A discussion focusing on conflict of interest will be scheduled for a future board meeting

VIII. Public Comment:

There was no public comment.

IX. Recess

X. Executive Session

XI. Voting

- a. The Executive Session Minutes from November 13, 2018 were approved unanimously.
- b. The motion to change to the Operating Agreement to reflect necessary financial and tax requirements was approved by a supermajority of the Board.
- c. The motion to approve the Governance Ad-Hoc committee's recommendation regarding changes to the Board composition and to subsequently amend the Operating Agreement to reflect these changes was approved by a supermajority of the Board.
- d. The motion to authorized leadership to enter into contract with the Department of Vermont Health Access for the Vermont Medicaid Next Generation Program for 2019 was approved by a supermajority of the Board.
- e. The Motion to approve the 2019 Budget as approved by the Green Mountain Care Board was approved by a supermajority of the Board.
- f. The motion to approve the resolution authority leadership to enter in to a contract with Blue Cross Blue Shield of VT for the Qualified Health Plan Payer Program for 2019 contingent on all acceptable terms as outlined by leadership was approved by a supermajority of the board.



XII. Other Business

There was no other business.

XIII. Adjourn

Upon a motion that was seconded, the meeting adjourned at 7:04 p.m.

DRAFT FOR APPROVAL



Attendance:

OneCare Board Members

- | | | |
|---|---|---|
| <input checked="" type="checkbox"/> Sierra Lowell | <input type="checkbox"/> Steven Gordon | <input checked="" type="checkbox"/> Joseph Perras, MD |
| <input checked="" type="checkbox"/> Jill Berry-Bowen | <input checked="" type="checkbox"/> Todd Keating | <input checked="" type="checkbox"/> Judy Peterson |
| <input checked="" type="checkbox"/> John Brumsted, MD | <input type="checkbox"/> Steve LeBlanc | <input checked="" type="checkbox"/> Toby Sadkin, MD |
| <input checked="" type="checkbox"/> Betsy Davis | <input checked="" type="checkbox"/> Steve Leffler, MD | <input checked="" type="checkbox"/> John Sayles |
| | <input checked="" type="checkbox"/> Judy Morton | <input checked="" type="checkbox"/> Kevin Stone |
| | <input type="checkbox"/> Mary Moulton | |
| | <input checked="" type="checkbox"/> Pamela Parsons | |

OneCare Risk Strategy Committee

- | | |
|---|--------------------------------------|
| <input checked="" type="checkbox"/> Tom Dee | <input type="checkbox"/> Tom Manion |
| <input checked="" type="checkbox"/> Jeffrey Haddock, MD | <input type="checkbox"/> Anna Noonan |

OneCare Leadership and Staff

- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> Todd Moore | <input checked="" type="checkbox"/> Tom Borys | <input checked="" type="checkbox"/> Linda Cohen Esq. |
| <input checked="" type="checkbox"/> Vicki Loner | <input checked="" type="checkbox"/> Sara Barry | <input checked="" type="checkbox"/> Spenser Wepler |
| <input checked="" type="checkbox"/> Karen Lee | <input type="checkbox"/> Susan Shane | <input checked="" type="checkbox"/> Amy Bodette |
| <input checked="" type="checkbox"/> Norm Ward, MD | <input type="checkbox"/> Joan Zipko | |
| <input checked="" type="checkbox"/> Greg Daniels | <input type="checkbox"/> Martita Giard | |