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Board of Managers Meeting

Tuesday, 7/18/2023
4:30 - 6:30 PM ET

1. **PUBLIC: Call to Order and Board Announcements Presented By: Anya Rader Wallack (4:30-4:31)**
2. **PUBLIC: Welcome Board Managers, Invited Guests, and Members of the Public Presented By: Anya Rader Wallack (4:31-4:32)**
3. **PUBLIC: Consent Agenda Items Presented By: Anya Rader Wallack (4:32-4:33) Approve**
   Motion and Vote to Approve Consent Agenda Items – Majority Required
   3a. 2023-07 Public Consent Agenda Cover Page - Page 3
   3b. 2023-06 Public Session Minutes. - Page 4
   3c. 2023-07 Board Committee Reports - Page 7
   3d. Summary of Policy Changes - Public Session 07-2023 - Page 8
   3d. 2023-07 Annual Compliance Work Plan for PY2023 - Page 9
   3f. 05-03 Network Development and Composition 07-18-23 - Page 15
   3g. 05-05 Contractual Signature Authority 07-18-23 - Page 17
   3h. 06-03 Policy Management 07-18-23 - Page 19
4. **PUBLIC: Governance Presented By: Anya Rader Wallack (4:33-4:40) Approve**
   Motion and Vote to Approve Resolution Appointing Manager to the Board of Managers – Supermajority Required
   4a. Sandy Rousse Bio - Page 22
   4b. 2023-07 Resolution Appointing Manager to the Board of Managers - Page 23
5. **PUBLIC: OneCare KPI and PHM Q1 2023 Data Report Out Presented By: Carrie Wulfman, Josiah Mueller (4:40-5:00)**
   5a. 2023-07 OneCare KPI and PHM Q1 Data Report Out - Page 24
6. **PUBLIC: Compliance Training Presented By: Greg Daniels (5:00-5:30)**
   6a. 2023-07 Compliance Training - Page 30
7. **PUBLIC: Public Comment, Move to Executive Session Presented By: Anya Rader Wallack (5:30-5:31) Approve**
   Motion and Vote to Approve Resolution to Move to Executive Session – Majority Required
   7a. 2023-07 Resolution to Move to Executive Session - Page 63

11. **PUBLIC: Votes Presented By: Anya Rader Wallack (6:16-6:20) Approve**
    Approve Executive Session Consent Agenda Items - Supermajority Required
12. **PUBLIC: Adjourn Presented By: Anya Rader Wallack (6:20)**
13. **PUBLIC FYI Documents**
    15a. 2023-07 Public Affairs Report - Page 87

OneCare Vermont Accountable Care Organization, LLC
Consent Agenda Cover Page

Public Session

July 18, 2023

Agenda Item	Reason for Review and Request for Approval
a. Consent Agenda Cover Page	Reference only.
b. Draft OneCare Public Session Minutes June 20, 2023	Review and approval of prior month's minutes.
c. Board Committee Reports July 2023	Summary of Board subcommittee meetings from the past month.
d. Annual Compliance Workplan PY2023	OneCare is requesting the Board following the Audit Committee's recommendation and vote to approve the Workplan.
e. Summary of Policies **f.** 05-03 Network Development and Composition **g.** 05-05 Contractual Signature Authority **h.** 06-03 Policy Management	Review and approval of listed policies; a summary of changes is provided.

OneCare Vermont Accountable Care Organization, LLC
Board of Managers Meeting
June 20, 2023
Public Session Minutes

A meeting of the Board of Managers of OneCare Vermont Accountable Care Organization, LLC ("OneCare") was held remotely via video and phone conference on June 20, 2023. Public access was also available at the OneCare Offices in Colchester, Vermont.

I. Call to Order and Board Announcements

Board Chair Anya Rader Wallack called the meeting to order at 4:33 p.m. Chair Wallack thanked Betsy Davis for her 8 years of service to OneCare's Board and its committees. Chair Wallack also asked for support from Managers in recruiting additional members to the Patient and Family Advisory Committee. The committee is interested in expanding diversity of its members. Management will share a draft recruitment letter that Managers can use to outreach within their communities.

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

Chair Wallack welcomed members of the public in attendance and offered the opportunity to introduce themselves.

III. Public Consent Agenda Items

The Board reviewed consent agenda items including: (1) Draft Public Session Minutes from May 30, 2023; and (2) Board Committee Reports June 2023.

An opportunity for discussion was offered.

A Motion to Approve the Consent Agenda Items was made by D. Bennett, seconded by Dr. J. Gilwee and approved by a majority.

IV. Incorporating Health Disparities Data and Accountabilities at Spring HSA Consultations

Chief Medical Officer, Dr. Carrie Wulfman, and Josiah Mueller, Director of Value Based Care presented information on how OneCare has been disseminating health disparities and social determinants of health data across its network. They reviewed data report templates, how these data were incorporated into spring HSA consultations, examples from three organizations committed to specific goals and actions in response to the data provided by OneCare, and upcoming plans for the next quarter.

Mr. Mueller also shared information about a food insecurity pilot conducted in the Rutland community. In this initiative, using OneCare data on individuals that may be food insecure, outreach was conducted for 800 community members, 500 were contacted and 40% expressed interest in learning more about and/or enrolling in 3SquaresVT.

Board Managers asked questions related to data sources and completeness and noted the importance of looking at both health disparities and social determinants of health.

V. Public Comment

There was no public comment.

VI. Move to Executive Session

A Motion to Approve the Resolution to Move to Executive Session was made by S. LeBlanc, seconded by T. Dee and was approved by a unanimous vote.

VII. Votes from Executive Session

1. Approve Executive Session Consent Agenda Items – **approved by supermajority via electronic vote.**
2. Approve Adopt Policies, Set PHM Targets, and Adopt Provider Accountabilities – **approved by supermajority via electronic vote.**

VIII. Adjournment

Upon a Motion made, seconded, and approved by a unanimous vote, the meeting adjourned at 6:31 p.m.

Attendance:

OneCare Board Managers

Present:

Dan Bennett	Shawn Tester	Toby Sadkin, MD
Bob Bick	Jen Gilwee, MD	Judi Fox
Coleen Condon	Leslie Ferrer	Tom Huebner
Tom Dee	Steve LeBlanc	Anya Rader Wallack

Absent:

Michael Costa	Stuart May	Sierra Lowell
John Sayles	Adriane Trout, MD	Teresa Fama, MD

J. Fox joined the meeting at 4:45 p.m.

T. Dee left the meeting at 5:56 p.m.

B. Bick left the meeting at 6:04 p.m.

OneCare Risk Strategy Committee

Absent:

Steve Leffler, MD		

OneCare Leadership and Staff

Present:

Abe Berman	Amy Bodette	Kellie Hinton
Sara Barry	Aaron Perry	Carrie Wulfman, MD
Greg Daniels	Lucie Garand	Tom Borys
Josiah Mueller		

OneCare Board of Managers Committee Reports

July 2023

Executive Committee (meets monthly)
The Executive Committee did not meet in July but did conduct an electronic vote to recommend a candidate to fill the home health seat on the Board of Managers. The committee is next scheduled to meet on August 3, 2023.

Finance Committee (meets monthly)
At its July 12 meeting, program settlement updates were provided for 2022-2023. An update on the 2022 financial audit was also provided, and a CMS financial guarantee was discussed. The committee also talked about the CPR program for year 2024 and 2023 Medicaid fixed prospective payments. The committee is scheduled to meet next on August 9, 2023.

Population Health Strategy Committee (meets monthly)
At its July 10 meeting, the committee had a presentation from the Camden Coalition on their care coordination efforts and efforts underway with the State of Vermont. An update was given about the 2024 PHM policy approval and its communication to network members. Incorporating health disparities in quality improvement was also discussed. Data surrounding potentially avoidable emergency department use was presented. The committee is next scheduled to meet on August 14, 2023.

Patient & Family Advisory Committee (meets monthly)
At its June 27 meeting, the committee heard discussed updates in regard to both the Board of Managers and Public Affairs. The majority of the meeting was a presentation and dialogue around care coordination outcomes. The committee is next scheduled to meet on July 25, 2023.

Audit Committee (meets quarterly)
The Audit Committee met on June 30th. Earnest and Young was invited to the meeting and presented their findings from their 2022 financial audit. Pending any changes, the committee accepted the report and recommended it be presented to the Board when it is complete. Additionally, a compliance work plan status update was presented and approved. The committee is next scheduled to meet on October 30, 2023.

Board of Managers Summary of Policy Changes

Public Session

July 2023

OneCare leadership has reviewed and recommends the following policies for approval by the Board of Managers.

- **05-03 Network Development and Composition**
  - **Purpose:** To outline the standards by which OneCare will meet key contractual obligations related to development and composition of the OneCare Network.
  - **Key Changes:** No substantive edits.
  - **Committee Endorsement:** N/A

- **05-05 Contractual Signature Authority**
  - **Purpose:** To establish uniform standards related to contractual signing authority that legally binds OneCare and to identify the individuals within the organization that have the ability to exercise that authority.
  - **Key Changes:** No substantive edits.
  - **Committee Endorsement:** N/A

- **06-03 Policy Management**
  - **Purpose:** To establish uniform guidelines for the development, review, approval, and management of OneCare policies.
  - **Key Changes:** The sections for Committee Endorsement and Board of Managers Approval have been added in order to further clarify these steps in the current process.
  - **Committee Endorsement:** N/A

Compliance Work Plan PY 2023: Overview — Pending Approval by the OneCare Vermont Board of Managers

OneCare's Annual Compliance Work Plan is intended to serve as a guidance and reporting document for the Board of Managers and Leadership that describes OneCare's planned compliance oversight activities for the Program Year. The Plan is developed by OneCare's Chief Compliance Officer and Compliance Team, with review and endorsement by the Compliance Committee and approval by the Board. The Compliance Committee retains the right to seek Board approval for material changes to the Plan during the program year.

The Plan is intended to be a living document, subject to change where necessary to incorporate new or changing priorities, changes to all applicable laws, regulations, payer contracts, and additional work projects arising out of the activities described in the Plan, and internal and external reports or complaints of non-compliance received. As such, the Plan will be updated on an ongoing basis and quarterly updates shall be reviewed by the Compliance Committee. The Plan will also be included in the CCPO's Quarterly Report to the Board and Audit Committee accompanied by an executive summary of status updates, relevant findings, material changes, and other noteworthy information.

The Plan is divided into the following tabs/sections: Audit Plan**,** Compliance Activities, Training & Education, DVHA Reporting, and DVHA Risk Assessments.

**The layout of the DVHA Program Integrity tabs is based on the template DVHA has provided for OneCare's quarterly Program Integrity Summary.*

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Audit Plan									Target Completion 2023				Corrective Action Plans	
Subject Area	Description	Audit Type	Internal/External	SME	Frequency	Reporting	Risk Level	Status	Q1	Q2	Q3	Q4	Corrective Action Plan: Y/N	High Level Summary of Corrective Action Plan
Program Integrity*	Audit areas of potential fraud, waste, or abuse identified through monitoring of Special Claims Data. Includes: 1. Overutilization of Covered Services for which prior-authorization has been waived, 2. Overutilization of Covered Services by Out-of-Network Providers, and 3. Overutilization of high-cost Covered Services with potentially low value to patient. *[See Risk Assessment sheet.]*	Audit	Internal	TBD/Greg Daniels, CCPO	As needed basis.	Payers	Medium	Ongoing	X	X	X	X	Y	[See Risk Assessment tab of this WorkPlan]
Compliance*	Review of the data certified to payers under the terms of ACO Program Agreements.	Audit	Internal	TBD/Greg Daniels, CCPO	Annual	Payers	Medium	Not started				X	N	
Quality*	Review Abstraction of quality metrics for ACO Programs.	Review	Internal	TBD/Greg Daniels, CCPO	Annual	Government Payers	Medium	Not started				X	N	
Privacy	Audit access by ACO Network and business associates to claims data and PHI stored in various data warehouses for compliance with HIPAA and terms of ACO Program Agreements and/or Data Use Agreements between OneCare and Payers.	Review	Internal	Greg Daniels, CCPO	Annual	OCR and/or Payers	Medium	Not started			X		N	
Privacy	Audit internal access by OneCare's Workforce to claims data and PHI stored in various data warehouses for compliance with HIPAA and terms of ACO Program Agreements and/or Data Use Agreements between OneCare and Payers.	Review	Internal	Greg Daniels, CCPO	Annual	OCR and/or Payers	Medium	Not started			X		N	
Security	Assess compliance with terms of Master Services Agreement with UVMHN regarding security and confidentiality of Special Claims Data.	Assessment	External Vendor	TBD/Greg Daniels, CCPO	Annual	OCR	Medium	Not started				X	N	
* These activities are to be updated once Sr. Compliance Auditor has been brought onboard.														
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Compliance Activities								Target Completion 2023					
#	Activity	Category	Responsible Staff	Frequency	Description	Reporting	Risk Level	Q1	Q2	Q3	Q4	Status	Notes
1	**Monitor Special Claims Data**	Program Integrity	TBD/Greg Daniels, CCPO*	Ongoing	Compliance monitoring of Special Claims Data to identify potential instances of fraud, Waste, or abuse.	DVHA	Medium	X	X	X	X	**Ongoing**	Under the VMNG Program Agreement for PY2023, DVHA changed the reporting requirements set forth in the Medicaid ACO Program Manual's template for Report #16 *Program Integrity* , requiring more specificity and detail from OneCare regarding it Compliance-related activities in the areas of auditing, monitoring, and investigations.
2	**Network Exclusion Screening**	Compliance	Greg Daniels, CCPO	Ongoing	Compliance monitoring of monthly debarment and exclusion screening.	CMS, DVHA, HHS OIG	Medium	X	X	X	X	**Ongoing**	Participate in any work group created to explore the use of specialized software or outside/third-party vendor to support this function.
3	**Data Use Committee**	Compliance	Greg Daniels, CCPO	Ongoing	Participate in oversight review and approval process for Special Data Requests performed by Data Use Committee in compliance with *03-03 Data Use Policy* .	DVHA	Medium	x	x	x	x	**Ongoing**	
4	**Contract Review and Approval**	Compliance / Contracting	Greg Daniels, CCPO	Ongoing	Review contractual agreements to ensure regulatory and legal compliance.	N/A	Low	X	X	X	X	**Ongoing**	
5	**Policy / Policy Update Review and Approval**	Compliance	Greg Daniels, CCPO	Ongoing	Review and analysis of new and revised policies for data, financial and related regulatory requirements.	CMS and DVHA	Low	X	X	X	X	**Ongoing**	
		* These activities are to be updated once Sr. Compliance Auditor has been brought onboard.											
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Training & Education							Target Completion 2023				
#	Topic	Training Group	Description	Format	Reporting	Frequency	Q1	Q2	Q3	Q4	Status
1	**Compliance Training: Board of Managers**	Board of Managers	Required training providing an overview of healthcare compliance and of the OneCare Compliance Program, including overviews on Privacy & Security, COIs, Code of Conduct, and how to detect and report FWA, with additional information on the Board's compliance oversight functions.	Meeting	CMS and DVHA	Annual			X		**Pending**
2	**Compliance Training: Workforce & Network**	ACO Network & Workforce	Required training providing an overview of healthcare compliance and of the OneCare Compliance Program, including overviews on Privacy & Security, COIs, Code of Conduct, and how to detect and report FWA.	eLearn	CMS and DVHA	Annual			X		**Pending**
3	**Patient Privacy, HIPAA, and Special Claims Data Privacy Training**	Workforce	Training providing an overview of HIPAA, 42 CFR PT 2, as well as permitted uses of data per DUAs/BAAs in place with payers and Network, and PHI & e-PHI safeguard reminders.	Meeting	CMS and DVHA	Annual			X		**Pending**
4	**Patient Privacy in relation to Care Coordination**	ACO Network & Workforce	Development in process of updated patient-privacy and data-use trainings and FAQs focusing on the expanded ability of Participants, Preferred Providers, and Collaborators to exchange PHI of attributed individuals among the various members of care-coordination teams through the Organized Healthcare Arrangement (OHCA) structure created by their participation in OneCare's ACO Network.							X	**Not Started/In Development**
5	**Conflicts of Interest Training: Board of Managers -** [Training being transferred to ACO Chief Legal Counsel]	Board of Managers and Management Team	Required annual training providing an overview of employment, financial and personal conflicts as they relate to members of the Board.	Meeting	CMS, DVHA, GMCB	Annual				X	**Pending**
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OneCare Vermont Compliance Program Risk Assessment #1 - March 31, 2023*

Top 3 Areas of Risk	Controls	Vulnerability	Risk	Corrective Action Plan
Overutilization of Covered Services for which prior-authorization has been waived.	Utilization Monitoring for Prior Authorization Reporting	Waste	In addition to the prior authorization requirement for certain Covered Services being waived, the edit and audit functions for such services have been turned off in the electronic claims submission system employed by DVHA, which results in all claims for these Covered Services not being subject to adjustment, yet being reimbursed. [*In light of changes to the prior authorization waiver for PY2023, further analysis of this risk over an extended period of review may yield a change in this assessment.*]	OneCare will develop a targeted list of codes where prior authorization is waived for 2023 and examine utilization trends through the Utilization Management workgroup in an effort to identify unwarrented deviations from the VMNG program's value-based arrangement.
Overutilization of Covered Services by Out of-Network Providers.	Utilization Analysis Reporting	Waste	Claims for services by OON Providers are reimbursed at FFS and accounted for in the calculation of Actual Total Cost of Care, which may impact whether shared savings can be achieved. OneCare has no authority to audit or otherwise investigate the legitimacy of such OON claims. Individuals attributed to OneCare have the right to choose their healthcare-services Provider regardless of whether the Provider contracts with OneCare to participate in the VMNG Program, consequently OneCare may not make any effort to influence that choice. Consequently, Out-of-Network (OON) Providers often render Covered Services to attributed individuals without OneCare having much transparency into whether utilization - or possibly overutilization - of Covered Services is an intended shift in utilization. Without further information regarding the legitimacy of such claims, referral to DVHA's SIU would be inappropriate as they cannot be categorized as being "identified, suspected, or alleged instances of fraud, waste, or abuse". [*In light of changes to the prior authorization waiver for PY2023, which impacts claims submitted by OON providers, further analysis of this risk over an extended period of review may yield a change in this assessment.*]	OneCare will monitor OON utilization/spend and report findings to DHVA SIU via its quarterly Program Integrity Report #16 rather than via its quarterly Program Integrity Referrals Report #17.
Overutilization of high-cost Covered Services with potentially low-value to patient.	Utilization Analysis Reporting	Waste	Certain Covered Services are routinely reimbursed, or zero-paid and included in the Base Period Claims used for calculating the Expected Total Cost of Care, regardless of whether the Services when rendered returned any value to the attributed individual or the VMNG Program.	OneCare will work to identify such services and, in alignment with its focus on Population Health Management, work to increase beneficiary engagement with primary care providers to drive appropriate sourcing of care and reduction of reliance on such low-value services.

Per the CMS Glossary (www.cms.gov/glossary), the following defintions apply to the terms Fraud, Waste, and Abuse:

Fraud refers to the intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).

Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicare(Medicaid) Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare(Medicaid) Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

*** This section includes only the summarized Top 3 Areas of Risk required by DHVA in the Risk Assessment. The complete Risk Assessment includes an Overview and Comeliance Program Scorecard.**

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ACO Name OneCare Vermont
Reporting Period: PY2023 Q1
Version: N/A
Report Name:

##	Compliance/Program Integrity Activities	Description of Activity	Compliance/Program Integrity	Responsible Individual	Narrative	
#1	**Audit Committee of Board of Managers - Reporting**	Draft and present quarterly written report concerning the status of the Compliance program to the Audit Committee of the Board of Managers.	**Compliance and Program Integrity**	Gregory Daniels, CCPO	Reporting includes discussion of issues including: program integrity, data privacy, exclusion screening, inqurieis and reports to the Compliance Hotline, contract review and approval, policy review and approval, as well as training and education for OneCare's Workforce, leadership team, and Network.	
#2	**Compliance Committee - Quarterly Meeting**	Lead quarterly meeting of Compliance Committee comprised of team leaders to conduct oversight of Compliance program.	**Compliance and Program Integrity**	Gregory Daniels, CCPO	Reporting includes discussion of issues including: program integrity, data privacy, exclusion screening, inqurieis and reports to the Compliance Hotline, contract review and approval, policy review and approval, as well as training and education for OneCare's Workforce, leadership team, and Network.	
#3	**Exclusion/Debarment Screening**	Screen Network Members against the HHS OIG's List of Excluded Individuals and Entities (LEIE) and against the GSA's SAM Exclusion database for individuals or entities excluded from participation in HHS Programs and from contracting with the federal government, respectively.	**Compliance and Program Integrity**	Gregory Daniels, CCPO	Screening activities for Q1 have revealed no matches between Network Members and either exclusion list.	
#4	**Training and Education**	Provide Training and Education to members of OneCare's Workforce, leadership, Board of Managers and Network in areas including: Compliance, Conflicts of Interest, and Data Privacy and Security	**Compliance and Program Integrity**	Gregory Daniels, CCPO	Various training and education programs to be conducted in Q2, 3, and 4 of PY2023.	
#5	**Risk Assessment Reporting - DVHA**	Conduct the first of two semi-annual risk assessments of OneCare's program for detecting and preventing fraud, waste and abuse as required under Section 10.4 of the VMNG Program Agreement PY2023.	**Compliance and Program Integrity**	Gregory Daniels, CCPO	Conducted and submitted the first PY2023 assessment of OneCare's Compliance program to identify and report the top 3 areas of risk to the VMNG Program. This assessment included review and analysis of internal reporting concerning utilitization and provider performance as well as internal discussions with members of the leadership team and various staff members and team leaders of the finance and data analytics functions.	
#6	**Data Use Committee**	Participate in the Data Use Committee conducting oversight of Special Data Requests submitted by Network Members in compliance with OneCare's Data Use Policy.	**Compliance**	Gregory Daniels, CCPO	Reviewed and approved or rejected numerous Special Data Requests for access to and use of Special Claims Data provided to OneCare for use in ACO Activities pursuant to certain restrictions set forth in various ACO Program Agreements or Data Use Agreements.	
#7	**Policy Review**	Review and analyze proposed new policies, as well as updates to existing policies, for compliance with current law and regulations.	**Compliance**	Gregory Daniels, CCPO	Reviewed and approved all draft policy updates prior to those drafts being submitted to OneCare's Board of Managers for approval.	
#8	**Contract Review**	Review and analyze proposed new contracts, as well as amendments to existing contracts, for compliance with current law and regulations.	**Compliance**	Gregory Daniels, CCPO	Reviewed and approved all qualifying contracts or contract amendments prior to execution of those contracts or contract amendments, repsectively.	
	Monitoring Activities*	**Description of Activity**	**Compliance/Program Integrity**	**Responsible Individual**	**Narrative**	
#7	**Utilization Monitoring**	Review and analysis of utlization reporting	**Program Integrity**	Gregory Daniels, CCPO	Conducted review and analysis of internal utilization monitoring reporting generated by data analytics team in an effort to identify indications of potential instances of fraud, waste, or abuse.	
#8	**Utilization Analysis**	Review and analysis of utlization analysis reporting	**Program Integrity**	Gregory Daniels, CCPO	Conducted review and analysis of internal utilization analysis reporting generated by data analytics team in an effort to identify indications of potential instances of fraud, waste, or abuse.	
#9	**Network Performance**	Review and analysis of network performance reporting	**Program Integrity**	Gregory Daniels, CCPO	Conducted review and analysis of internal network performance reporting generated by data analytics team in an effort to identify indications of potential instances of fraud, waste, or abuse.	
					There were no reports or inquiries either internally, anonymously, or via OneCare's Compliance Hotline, concerning indications of potential instances of fraud, waste, or abuse concerning the VMNG Program.	
	Reviewing/Auditing/Investigating Activities	**Description of Activity**	**Compliance/Program Integrity**	**Responsible Individual**	**Narrative**	**Outcomes**
#10			**Program Integrity**	Gregory Daniels, CCPO	OneCare's monitoring activities did not generate follow-up reviewing, auditing, or investigative activities during Q1 of PY2023.	N/A

* Pursuant to OneCare's Compliance Policy and Code of Conduct, all members of OneCare's workforce, including individuals performing data analytics and financial analysis functions, are required to report any indications they identify of potential instances of fraud, waste, or abuse either internally or anonymously.

Policy Number & Title:	05-03 Network Development and Composition
Responsible Department:	Contracting
Author:	Martita Giard, Director, ACO Contracting
Original Implementation Date:	January 1, 2017
Board Approval Date:	July 18, 2023
Revision Effective Date:	July 18, 2023

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

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

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

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

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

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

3. If OneCare declines participation to a health care provider or other organization who requests network participation, it shall inform that provider or organization of that decision in writing. A health care provider who has been declined may appeal that determination as permitted by policy *05-07 Provider Appeal of Denial of Participation in ACO*.

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

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

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

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

VI. References:

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

VII. Related Policies/Procedures:

- 05-07 Provider Appeal of Denial of Participation in ACO

Location on SharePoint: Department: Policies, Category: Active

Management Approval:

Director, ACO Contracting	Date
Chief Operating Officer	Date

Policy Number & Title:	05-05 Contractual Signature Authority
Responsible Department:	Contracting
Author:	Martita Giard, Director, ACO Contracting
Original Implementation Date:	July 22, 2020
Board Approval Date:	July 18, 2023
Revision Effective Date:	July 18, 2023

I. **Purpose:** To establish uniform standards related to contractual signing authority that legally binds OneCare Vermont (OneCare) and to identify the individuals within the organization that have the ability to exercise that authority.

II. **Scope:** Applicable to any OneCare Workforce and all forms of a Contract entered into by OneCare including those that are drafted by OneCare independently, jointly drafted Contracts, and Contracts proposed by other parties.

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

IV. **Policy:**

A. All legally binding Contracts must be signed by a Responsible Signatory. OneCare will not recognize contracts that are not executed by Responsible Signatories. If a contract is signed by someone other than a Responsible Signatory, that contract may be ratified and accepted by the signature of a Responsible Signatory. OneCare Workforce who attempt to or who do enter into a Contract without authority, or compliance with Policy 05-01 Contract Management may be subject to disciplinary action.

B. A Responsible Signatory is required to comply with the requirements of Policy *05-01 Contract Management* before executing a Contract.

C. The annual ACO Financial Audit Commitment Letter must be signed by a Responsible Signatory.

D. Invoices or other payments related to active Contracts will be paid according to the terms of that Contract.

V. **Review Process:** This policy will be reviewed annually.

VI. **References:**

- OneCare's Policy and Procedure Glossary

VII. **Related Policies/Procedures:**

- 04-06 Disbursement Authority Policy
- 05-01 Contract Management Policy

Location on SharePoint: Department: Policies, Category: Active

Management Approval:

Director, ACO Contracting	Date
Chief Operating Officer	Date

Policy Number & Title:	06-03 Policy Management
Responsible Department/s:	Operations
Author:	Joan Zipko, Director, Operations
Original Implementation Date:	January 1, 2017
Board Approval Date:	July 18, 2023
Revision Effective Date:	July 18, 2023

I. **Purpose:** To establish uniform guidelines for the development, review, approval, and management of OneCare Vermont ("OneCare") policies.

II. **Scope:** Applicable to the OneCare Workforce as stated in this Policy.

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

IV. **Policy:** To document expectations for the management and operations of OneCare and effective ACO programs, OneCare develops and maintains written policies for each department, team, or functional area (collectively "functional area") in compliance with its obligations under the Vermont All-Payer Accountable Care Organization ("ACO") Model Agreement ("VAPAM Agreement") and applicable federal and state laws, rules, and regulations, as well as with its obligations under agreements with Payers and other contracts related to the furtherance of the ACO business model.

1. **Development of New Policies**
   The director of each functional area, in collaboration with their direct supervisor and any relevant subject-matter experts ("SME") and stakeholders, will assess the need for, and define the scope of, any new or materially updated policies. The Chief Compliance and Privacy Officer ("CCPO") and/or Chief Legal Counsel ("CLC") may also identify the need for policies in an operational area and will work with the appropriate leader(s) to develop the policies as needed.

2. **Review and Update of Existing Policies**
   The director of each functional area, in collaboration with their direct supervisor and any relevant SMEs and stakeholders, will perform reviews of all active Policies annually, as well as on an interim basis, when warranted. The CCPO and/or CLC will participate in the annual or interim review where there are compliance or legal issues, or otherwise upon request. The Chief Operating Officer ("COO"), Chief Medical Officer ("CMO") and Chief Financial Officer ("CFO") may participate where they are a required signatory, upon request, or at their discretion.

   a. Annual Review: All policies shall be reviewed on an annual basis and updated as needed.

   b. Interim Review: Policies may be reviewed and updated outside of the annual review cycle if warranted by changes in: federal or state law, rules or regulations, related policies, terms of an ACO Program Agreement or a contract related to ACO business operations, program changes, at the direction of the Board of Managers ("Board"), or other unforeseen circumstances.

3. **Compliance & Legal Review**
   The CCPO and CLC shall review all new or updated policies while in final draft form ("final draft policy"). The CCPO and CLC shall review the final draft policy to ensure compliance with federal or state law, rules or regulations, related policies, ACO Program Agreements and any other contract

related to ACO business operations. If changes to the Policy occur after compliance and legal reviews have taken place, the CCPO and CLC will review those changes before the policy is approved by the Board.

4. **OneCare Executive Approval**
   Upon completion of the Compliance and Legal Review, Policies must be approved by the COO, CMO and/or CFO in accordance with the subject matter of the Policy.

5. **Committee Endorsement**
   Following OneCare Executive Approval, policies will proceed to any applicable Board Committee for endorsement. The Executive Approval team will determine the needs for Committee endorsement based on the content of the policy.

6. **Board of Managers Approval**
   Following any applicable Committee endorsement, policies will be presented to the Board for approval. Policies must complete all above steps in the process to be recommended to the Board for approval.

7. **Retirement of Policies**
   If a policy is determined to be obsolete due to a change in federal or state law, rules or regulations, a term in an applicable contract, or change in program design, retirement of that policy shall be requested of the Board. Upon Board approval of an update to an existing policy, the prior version will be automatically retired on the effective date of the updated policy.

8. **Management of Policies**
   The Director, Operations is responsible for managing the processes by which OneCare develops, reviews, retires, and archives policies; providing internal and external access; providing Workforce training; and monitoring adherence to this policy to inform process improvements.

V. Review Process: This Policy shall be reviewed annually and in accordance with the terms of this Policy.

VI. References:

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

VII. Related Policies/Procedures:

- 06-01 Record Retention Policy
- O05-46 Management of Policies Procedure

Location on SharePoint: Department: Policies, Category: Active

Management Approval:

Director, Operations	Date
Chief Operating Officer	Date

Sandy Rousse, CPA

Sandy Rousse, CPA, President & CEO Sandy Rousse has served as President and CEO of Central Vermont Home Health & Hospice since 2012. Sandy's affiliation with CVHHH began 20 years ago when she joined the Board of Directors. Before assuming her current role, she served as CFO, where she oversaw finance and information technology, and COO, where she oversaw finance, IT, long term care programs, and clinical operations.

Sandy possesses extensive knowledge of the home health and hospice industries and has participated in multiple health reform stakeholder workgroups in Vermont. She has in-depth knowledge of delivery system and payment reform. Sandy is passionate about community-based healthcare and its role in population health. "Home care providers have a wealth of information about their clients that could be extremely valuable in helping providers across the care continuum more fully understand how environmental factors impact a person's medical condition. I am driven to find innovative solutions that can assist Vermont providers to improve health outcomes and care coordination for Vermonters."

Sandy is a member of the OneCare Vermont Finance and Population Health Strategy Committees, the University of Vermont Health Network (UVMHN) Planning and Finance Committees, the Vermont Health Information Exchange Steering Committee, and the Green Mountain Care Board Nominating Committee. She is also a member of the Central Vermont Medical Center (CVMC) Board of Trustees.

Sandy is an accountant by trade and is a Corporator of Northfield Savings Bank. Sandy is a member of the VT Society of CPAs, the Barre Rotary Club, and the Barre City Police Advisory Committee. She lives in Barre City with her husband and has a daughter in college.

OneCare Vermont

OneCare Vermont Accountable Care Organization Board of Managers Resolution Appointing Board Managers July 18, 2023

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

The Board, having reviewed and discussed the recommendations of the Nominating Committee and the qualifications of the candidate, hereby elects to seat the following Manager:

A. Sandy Rousse, President and CEO of Central Vermont Home Health and Hospice, for the remainder of the current home health seat term, ending on December 31, 2023.

KPIs & PHM Update

July 2023

Key Performance Indicators (KPIs)

- UVM College of Medicine Consultants (December, 2022)
- Board of Manager approved 11 KPIs in (January, 2023)
  - Population Health Model (PHM) measures included in list
- Used as guide to Arcadia reporting development
- Today's goal: review early 2023 results

Key Performance Indicators (KPIs)

OneCare's 11 key performance indicators (KPIs) are designed to measure our success in controlling health care spending while supporting high quality care. Within the 11 KPIs are six priority measures, collectively referred to as OneCare's PHM, a streamlined approach to quality, care coordination and finance, where payments are bundled into a single stream.

KPI	PHM Focus
Total PMPM Spend	**No**
Primary Care Visits PKPY	**No**
Inpatient Admissions (Medical and Surgical)	**No**
Hospice LOS	**No**
Hospital Discharge to SNF, IP Rehab, and Home Health	**No**
Potentially Avoidable ED Visits	Yes
Diabetes Poor Control	Yes
Child & Adolescent Well	Yes
Developmental Screening First Three Years	Yes
Age 40+ Annual Wellness Visits	Yes
Hypertension Follow-up Visit	Yes

PHM KPIs Update – 2023 ACO Cohort

	Measure Name	PHM Measurement Level	Target	2021	2022	2023 (Jan & Feb)**	Target Met?
	Child & Adolescent Well Visits	Practice	57.5%	55.6%	53.9%	57.7%	Yes
	Developmental Screening	Practice	57.4%	60.1%	60.6%	60.8%	Yes
Inverse Measures	Diabetes A1c Control*	Practice	39.9%	10.0%, 16.3%, 32.0%	10.0%, 19.7%, 26.8%	TBD	TBD
Inverse Measures	40+ Annual Wellness	Practice (if N<300, HSA)	10% Improvement	57.0%	54.3%	53.5%	No
Inverse Measures	Potentially Avoidable ED Visits	HSA	10% Improvement	35.5%	33.0%	33.1%	No
Inverse Measures	Initial HTN or High BP Follow-up	HSA	10% Improvement	62.0%	63.3%	63.1%	No
Inverse Measures	Routine HTN or High BP Follow-up	HSA	10% Improvement	21.7%	21.9%	22.2%	No

Note: data source is claims received through 5/31/23 for Medicare, Medicaid, and MVP
*Diabetes A1c 2021 and 2022 results from VBIF program for Medicare, Commercial, and Medicaid Populations respectively
**Preliminary data; seasonality not accounted for in this two month timeframe

KPIs Update – 2023 ACO Cohort

Measure Name	2020	2021	2022	2023 (Jan & Feb)
Total PMPM Spend	$300	$355	$405	$409
Primary Care Visits PKPY	2,939	3,173	3,077	2,975
Inpatient Admissions PKPY	62.6	65.1	78.5	82.2
Hospice LOS	***			
Hospital Discharge to Home Health**	29.1%	27.6%	***	***
Hospital Discharge to SNF**	15.7%	15.9%	***	***
Hospital Discharge to IP Rehab**	2.8%	2.1%	***	***

Note: data source is claims received through 5/31/23 for Medicare, Medicaid, and MVP except as noted below
*Preliminary data; seasonality not accounted for in this two month timeframe
**Data source is OneCare Medicare benchmarking results
***Data not yet available

Lessons Learned and Next Steps

- Too many KPIs
- Overly complicated (e.g. discharge to post-acute care has 3 components)
- PHM Measures and KPIs could be separated
- 2024 & beyond: management discussing Objectives and Key Results (OKRs) vs KPIs
- Communication and dissemination
- Influencing meaningful change

Annual
Compliance Training

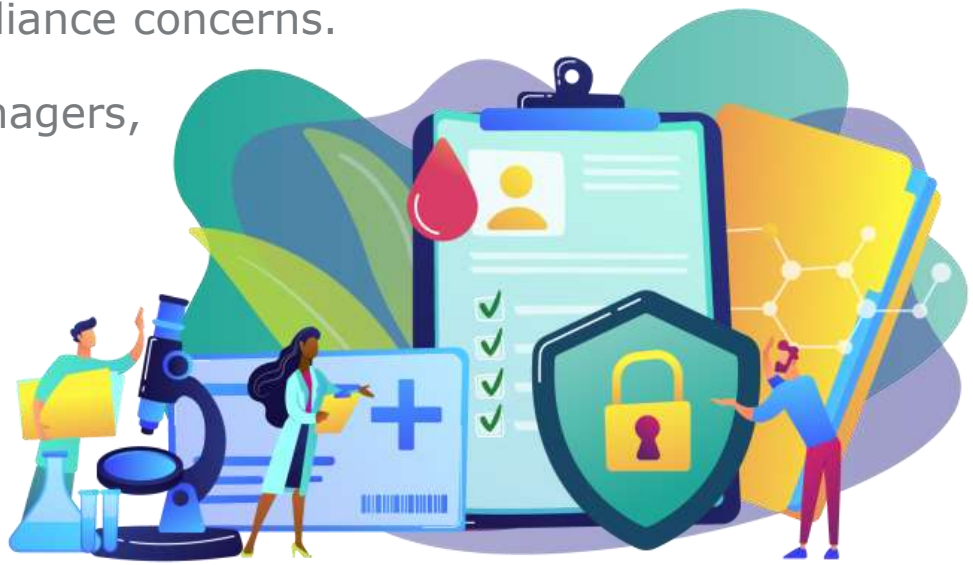
Board of Managers
2023

OneCare Vermont

onecarevt.org

Introduction

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



The Seven Pillars of an Effective Compliance Program

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

The Five Questions

Should I Check with Compliance? The Five Questions

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

Four Main Areas of Healthcare Compliance

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

HIPAA Privacy and Security

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

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

HIPAA Privacy and Security, *continued*

Concepts to Know:

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

HIPAA Privacy and Security, *continued*

Concepts to Know, Continued:

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

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

HIPAA Privacy and Security, *continued*

Permitted Uses and Disclosures of PHI:

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

1. **Individual**

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

   - **Treatment:** coordination of healthcare related services between one or more health care providers.

   - **Payment:** premiums, coverage, reimbursement for healthcare delivered.

   - **Healthcare Operations**: quality assessment & improvement activities including care coordination, audits, fraud & abuse detection and insurance functions, etc.

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

HIPAA Privacy and Security, *continued*

In addition to HIPAA's Permitted Uses and Disclosures, PHI in OneCare's possession or control is subject to OneCare's *03-03 Data Use Policy*:

Any PHI meeting the definition of Data set forth in OneCare's *03-03 Data Use Policy* - including Claims Data, Clinical Data, De-Identified Data, and Other Data - is subject to the uses and restrictions of that policy.

Claims Data refers to the claims feed and enrollment information for Attributed Lives provided by Payers to OneCare. These data include original data files as well as any subcomponents or subgroups of the original data file.

Clinical Data refers to the data elements that describe an individual's condition throughout a medical encounter and includes, *for example*, data about an individual's symptoms and complaints, physical exam findings, laboratory and radiology results, and assessments and may be obtained through various sources including VITL and electronic health records. Clinical Data are separate and distinct from Claims Data, which may include related information such as procedure codes, for example.

Other Data refers to data related to healthcare services or business operations of OneCare or its network that is not PHI Data, Claims Data, Clinical Data or De-Identified Data.

Conflicts of Interest

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

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

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

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

Conflicts of Interest

Conflict of Interest is a **Personal Interest** that may create a real or perceived conflict with the professional obligations or fiduciary duties of an **Interested Person** or the interests of OneCare and may adversely affect business or professional decisions.

Interested Person refers to OneCare's Officers and Board Members, its Director of Value Based Care, members of its Population Health Committee, as well as any member of its Workforce who exercises substantial influence over OneCare's business decisions or affairs.

Personal Interest refers to a **Financial Interest**, **Compensation Arrangement**, or **Fiduciary Interest** with or in a Network Member, Subcontractor, or Vendor by the **Interested Person**, a member of their **Immediate Family**, their **Significant Other**, or their **Controlled Entity**.

Compensation Arrangement means any employment, consulting, or other arrangement involving the receipt of money or other financial benefits during the past three years, or the receipt of gifts or gratuities that is not permitted by a relevant OneCare policy.

Conflicts of Interest

Controlled Entity means an entity in which an **Interested Person** has a 35% or greater ownership or beneficial interest.

Fiduciary Interest means participation as a trustee, director or officer of a Network Member, Subcontractor, or Vendor.

Financial Interest means any direct or indirect ownership interest in a Network Member, Subcontractor, or Vendor.

Immediate Family means an **Interested Person's** spouse, parent or step parent, children and their spouses, as well as brother(s) and sister(s) and their spouses.

Significant Other means a person with whom an Interested Person has a civil union or a similar legal or personal relationship.

Conflicts of Interest

An **Interested Person** may not place **Personal Interests**, the interests of **Immediate Family** members, or the business interests of another organization they may be affiliated with above the interests of OneCare.

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

Conflicts of Interest, *continued*

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

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

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

Examples of Potential Conflicts of Interest:

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

The False Claims Act

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

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

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

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

The False Claims Act, *continued*

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

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

Does OneCare submit "claims"?

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

The Stark Law & The Anti-Kickback Statute

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

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

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

In January of 2021, CMS/HHS issued revised Physician Self-referral law ("Stark Law") exemptions as well as safe harbors under the Anti-Kickback Statute (AKS), which contained broad new allowances for "value based arrangements"; defined as arrangements involving at least one "value based activity" for a target population.

To qualify for an exemption or safe harbor, the value based arrangement must involve a "value based enterprise," which consists of two or more participants or providers collaborating through care coordination to increase efficiencies in delivering care and improving patient outcomes. (e.g. an ACO)

Because the Stark exceptions are not identical to the AKS safe harbors, separate analyses are necessary to determine whether an exception or safe harbor applies to a particular value based arrangement.

However for any to apply, the value based arrangement must be reasonably designed to achieve its goals, it must work in practice, and the parties must monitor their arrangements.

If any party identifies or learns of an issue(s) that might impact the applicability of an exemption or safe harbor, they must "act quickly to rectify the ineffectiveness of their value based activities", and modify or terminate them.

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

Two new AKS Safe Harbors of note:

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

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

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

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

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

ACO Beneficiary Incentive Program:

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

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

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

ACO Waivers available are for the following:

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

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

Risk Areas for ACOs

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

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

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

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

Risk Area: Stinting on Care or Over-Utilization

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

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

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

Risk Area: Beneficiary Outreach and Marketing

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

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

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

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

Risk Area: Patient Choice

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

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

Risk Area: Inducements to Patients

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

Code of Conduct

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

Duty to Report and Non-Retaliation

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

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

Board Oversight of the OneCare Compliance Program

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

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

  1. A corporate information and reporting system exists; and

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

Board Oversight, *continued*

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

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

Board Oversight, *continued*

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

Board Oversight, *continued*

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

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

OneCare Policies

OneCare Compliance Policies

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

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

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

Speak Up about Compliance Concerns

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

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

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

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

Local: 802-847-7220

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

OneCare Vermont

OneCare Vermont Accountable Care Organization Board of Managers Resolution to Move to Executive Session July 18, 2023

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

The Board will now move into executive session in order to discuss subjects that are outside of the scope of the ACO's public meetings. For this meeting those include: (1) subjects that are or use trade secret information; (2) status of ongoing contract negotiations; and (3) confidential attorney-client communications.

OneCare Vermont

Public Affairs Report | July 2023

Media Coverage

Green Mountain Care Board subpoenas OneCare for salary details

June 29, 2023, VTDigger

Coverage of Green Mountain Care Board's (GMCB) subpoena issued on OneCare CEO, Abe Berman, for executive salary information after OneCare stated in a response letter that OneCare would not provide that level of employee information requested by the GMCB's as part of their order for OneCare Vermont to put a ceiling on executive compensation for the current fiscal year.

Rutland Regional announces Judi Fox as President & CEO

June 23, 2023, Bennington Banner

Announcement of OneCare board member, Judi Fox, as permanent President and CEO of Rutland Regional Medical Center.

Regulators flash sharper teeth on OneCare practices, executive pay

June 16, 2023, VTDigger

Coverage of Green Mountain Care Board approval of amended 2023 budget and of the two parallel orders asking OneCare to (1) track hospitals' use of money intended for affiliated primary care practices, and (2) put a ceiling on executive salaries for the current fiscal year, requiring that the money saved be spent on supporting primary care practices.

VT health care regulators pass OneCare Budget aimed at accountability

June 16, 2023, WCAX

This coverage is similar to the VTDigger coverage of the budget approval with the two parallel orders, focusing more heavily on the scrutiny of how funds have been allocated in hospital-based primary care; and with the perspective included from OneCare board chair, Anya Rader Wallack, that OneCare is not a silver bullet. Wallack points out in this piece that Vermonters may need to temper their expectations and better understand what OneCare exists to do in the broader healthcare reform landscape.

Government Relations

State Legislative Update

There are no legislative updates at this time.

Green Mountain Care Board (GMCB)

At its June 21st meeting the GMCB continued to discuss the Medicare Only ACO Guidance. The GMCB staff presented the proposed All-Payer ACO Budget Guidance and Certification Form review. The board discussed information they would like to be included in the 2024 budget guidance. As a result, additional information was requested from OneCare for consideration. This information was provided to the GMCB and the GMCB will continue its discussion and vote on July 14.

At its June 28 meeting the GMCB was provided updates from the Agency of Human Services (AHS) on the All Payer Model, as well as an update on the Hospital Sustainability and Global Payment Model Development by GMCB and AHS. The GMCB was also provided with an update on the evolution of the hospital budget process and voted to approve the Medicare Only ACO Guidance.

Outreach and Advocacy

Events, Shares, Articles, and Resources

OneCare continues to seek a highly skilled senior health care analyst. If you know of anyone who is a good fit for this position, please click here to learn more and apply: Finance and Accounting Job: Senior Healthcare Analyst – OneCare Vermont ACO at The University of Vermont Health Network in UVMMC - OneCare (uvmhealthnetworkcareers.org)

June was Alzheimer's and Brain Awareness Month. OneCare shared the Vermont Health Department's campaign to raise awareness about brain health on our social media channels. You can learn more about the campaign here: Brain Health & Dementia | Vermont Department of Health (healthvermont.gov)

The Keene Sentinel recently reported on the new Brattleboro Retreat transportation program. OneCare highlighted the connection to our waivers. Read the article: Nearly 100 mental health patients use new Retreat transportation program | Health Reporting Lab | sentinelsource.com

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

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