Operationalizing DCE Compliance

NAACOS SPRING 2022 CONFERENCE

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Panelists

Kimberly Busenbark currently serves as the Compliance Officer for 10 DCEs and has over a decade of experience helping organizations meet their compliance requirements under CMS Value-Based Programs. Since 2015, WRG has helped more than 65 ACOs and DCEs across the country remain compliant and be successful within the Shared Savings Program, the NextGen ACO Model and the GPDC Model. WRG is currently working to help several organizations apply and prepare for the ACO REACH Model.

Kimberly is a graduate of Texas A&M University, where she received a Bachelor's of Business Administration in Marketing and Management, and of The University of Houston Law Center, where she received her Juris Doctorate before being admitted to the State Bar of Texas.

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Panelists

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Kim Kauffman is vice president of clinical performance at Aledade, Inc. In this role, she supports value-based care contracts with CMS/CMMI, Medicare Advantage, commercial health plans and Medicaid managed care by working with teams that specialize in clinical documentation integrity, quality reporting, pharmacy, clinical outcomes improvement, patient outreach and post acute coordination. Prior to joining Aledade, Ms. Kauffman was the chief VBC officer for MaxHealth, a primary care group based in Florida with 120+ providers, and, before that, was chief VBC officer for Summit Medical Group, a primary care group with 300+ providers based in Tennessee. Her background includes a leadership role in a large independent physicians' association (IPA) in Florida and in a multi-hospital physician hospital organization (PHO). She received her master's degree from the college of public health at the University of Florida

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Panelists

Michelle Leslie currently serves as the Senior Vice President of Population Health for MaxHealth as well as the Executive Director for 2 DCEs. Michelle has over a decade of experience working with providers to improve the quality of healthcare while lowering the cost of care. Michelle began her career with WellMed Medical Management, which later became part of Optum, primarily focused on aligning with providers to successfully improve clinical outcomes and cost for Medicare Advantage members. During Michelle's tenure with Optum, she led the implementation of Optum's first Florida Medicare Shared Savings Program ACO. Michelle assisted with developing initial processes for the DCE and recently assumed the role of Executive Director for both DCEs.

Michelle is a graduate of Indiana University, where she received a Bachelor's of Arts in Criminal Justice, and of Indiana University School of Law Indianapolis, where she received her Juris Doctorate before being admitted to the State Bar of Texas and Florida.

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How to Ace a Compliance Session

- **Ask questions,** but pretend it was your friend's idea
- Don't sit with "creative" people – guilt by association (you know who you are)
- Laugh if Kimberly makes a joke
- **Freely offer comments and suggestions**
- Nod like you understand what Kim and Michelle are talking about
- Email your compliance officer in a panic
- **Help Us! Join the discussion!**

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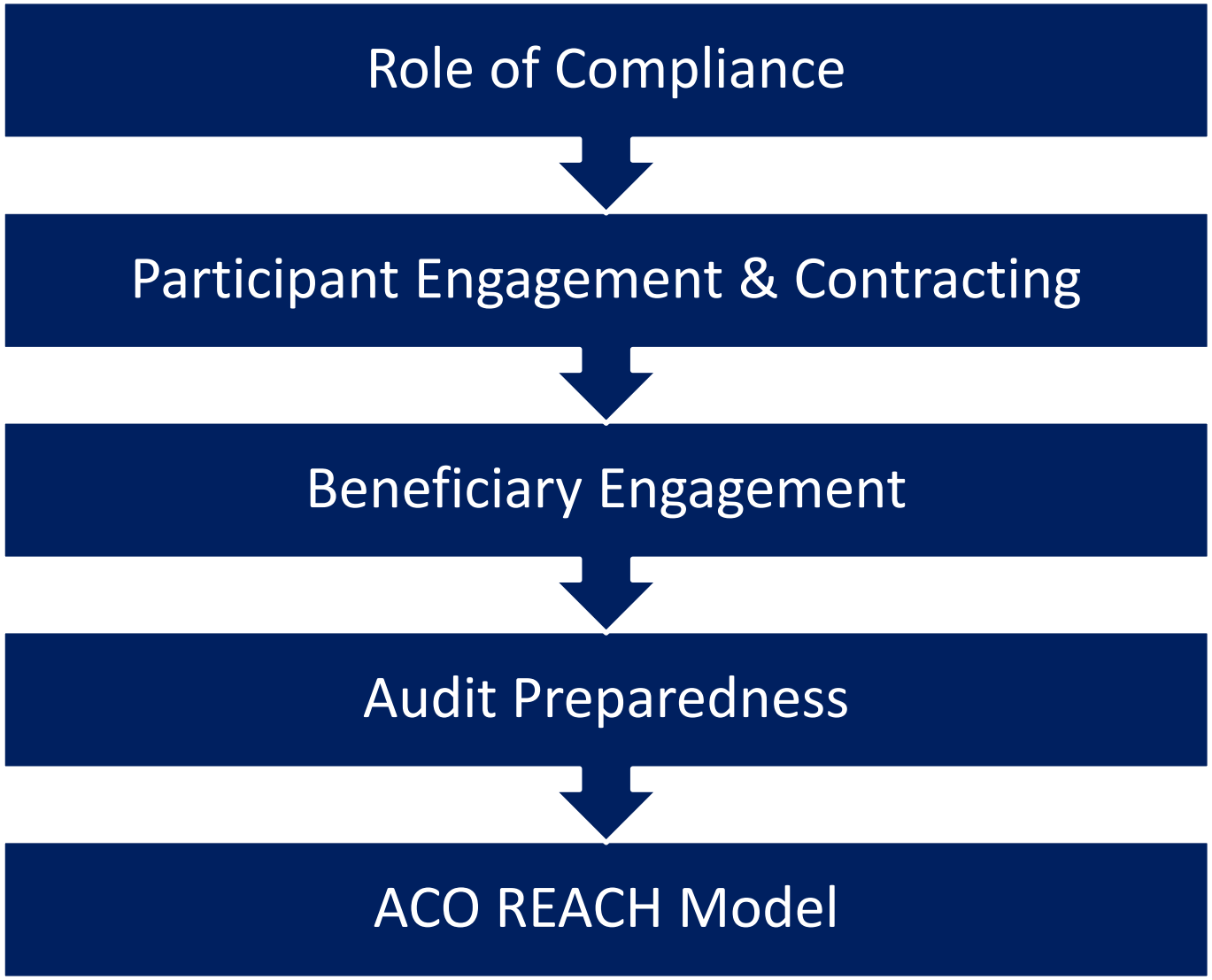
Operationalizing Compliance Topics



Role of Compliance

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Compliance Program Requirements

DCE Compliance Program requirements are the same as those required under the Shared Savings Program and the Next Generation Model. The Compliance Program must contain the following 5 elements:

The ACO REACH Model has the same requirements, plus a 90-day training specification.

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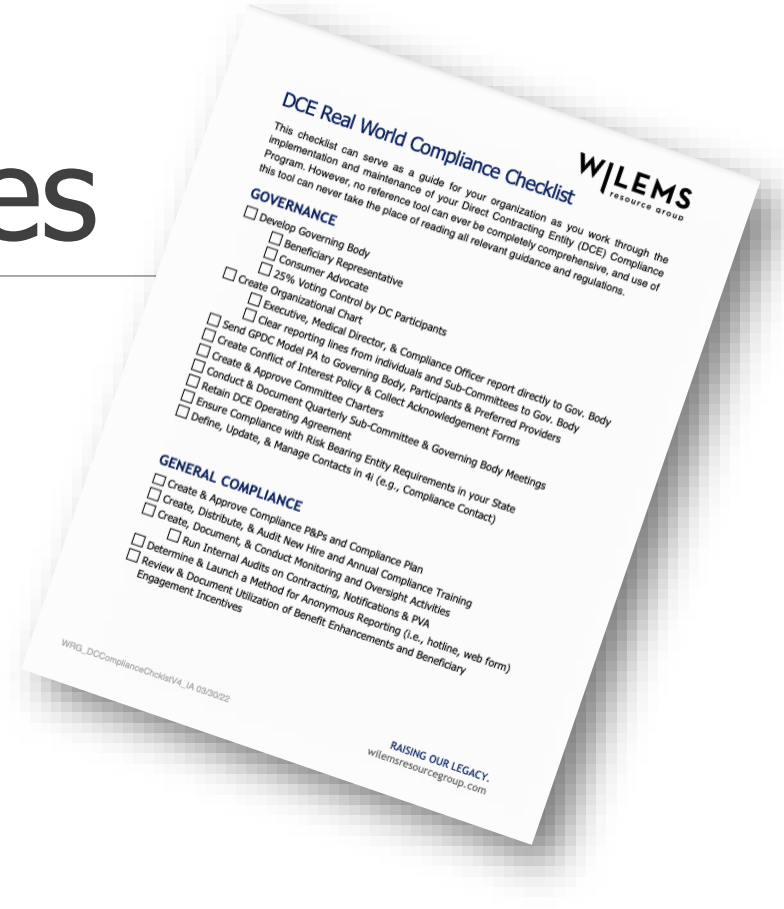
Checking Compliance Boxes

- Governance Requirements
- Creation of a Formal Compliance Plan
- Adoption of Compliance and Operations Policies & Procedures
- Effective Compliance Training – Annual & New Hire
- Anonymous Reporting – Hotline or Online Tool
- Data Use Requirements
- Marketing Material Compliance
- Development of a Monitoring and Oversight Program



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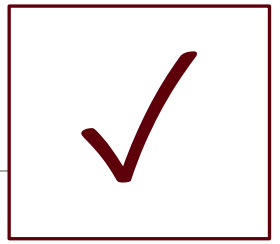
Effective Compliance



- Collaborating with Operations to Develop Compliant Strategies for Success
- Working with Participants to Identify Economies Across Compliance Requirements
- Overseeing Compliance with Operational Processes and Regulatory Guidance
- Serving as a Liaison Between CMS and the ACO/DCE
- Balancing Risk, Practice Requirements, and Financial Burden
- Brainstorming with ACO Leadership and Operational Teams to get to “Yes”
- Applying Common Sense to Regulatory Requirements
- Preparing Successful Audit Response

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Compliance Official Interaction

- Third Party vs In-House (and everything in between)
  - Compliance Officer may be an attorney, but may not be legal counsel to the ACO/DCE
- Level of Integration with Operations
- Reporting Structures - must have a dotted line to Governing Body, but does not require regular reporting to that entity
- Enforcement vs Police Force
- Top-Down Support
  - Governing Body
  - Executive and Medical Director

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Balancing Resources

- Risk vs Requirements
  - Example: Medicare Revalidation
- The Compliance Sovereign – your Compliance Officer must have the ability to enforce compliance as he or she feels is necessary (within reason).
  - Finances vs Compliance
  - Independent Practices
  - Support of Leadership
- Annual Risk Assessments are a useful tool for collaborative risk and finance management.

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Provider Engagement & Contracting

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Provider Engagement & Contracting

- Compliant Contracting
- Roster Management
- Provider Payments
- Provider Engagement
- Financial Arrangements Safe Harbor
- Red Flags for Provider Incentives

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Provider Contracting

- GPDC and ACO REACH require downstream contracts at the NPI level unless all exceptions are met:
  - ✓ The TIN is Medicare enrolled legally authorized to sign for the providers
  - ✓ There is an employment or contractual arrangement allowing the TIN to sign on behalf of the provider
  - ✓ Each Provider's name and NPI is listed in the agreement
  - ✓ All arrangement language requirements from the Model PA
  - ✓ The TIN is the same participant type as the individual providers (Participant or Preferred Provider)
    - ➢ Note: Multi-specialty groups are problematic

- Fee Reduction Agreements
  - Must be signed annually
  - May be signed at the TIN level
  - Must list each NPI

- Notification Requirements

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Roster Management

Deadline for PY 2023
August 4, 2022

- Prior to & during Performance Year
- Prior to PY = “Final” Provider Roster
  - Notification Requirements: written notification to NPI and TIN/Entity Executive; **anticipated deadline 7/28**
  - Provider must be included on this Roster in order to take a fee reduction for PY 2023
- Monthly Ad-Hoc Additions & Deletions Process = window opens at beginning of each month
  - Additions are effective on the first day of the next month
  - Terminations are effective on the last day of the same month
    - Must be submitted “prior to” the effective date of the termination

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Roster Management

Adding Providers During a PY

Ad-hoc additions are allowed **if it meets one of three** acid tests:

1. At time of being added, bills for services under a TIN that was on the Final Provider Roster AND Provider did NOT bill under that TIN when Final Provider Roster was submitted
2. Provider bills under a TIN that has been acquired by or merged with a TIN that was on the Final Provider Roster
3. Provider was on Final Provider Roster but was dropped due to overlap that has since been resolved

➢ **Ad-hoc Providers do NOT bring claims-based aligned pts**

✗ CANNOT participate in Fee Reduction or payment mechanisms (cap)

✓ CAN participate in Voluntary Alignment

✓ CAN participate in Benefit Enhancements

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Provider Payments

- Must be made with 30-days of DCE receipt or as agreed to in your financial arrangement

- Things to consider:
  - For cap, consider the 30-day requirement when building process/timeline for any retroactive reconciliation
  - How to structure payments for appropriate incentives
    - Cap, FFS, enhanced FFS or combo (compliant with Fee Reduction Agreement)
    - Delineate obligations such access, AWV, TCM, etc.

➢ Ensure communications and recruitment tools are compliant

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Provider Engagement

Financial Arrangements Safe Harbor

- Arrangement is **reasonably determined** to advance goals of the Model
- Arrangement does not induce providers to furnish unnecessary services or reduce necessary services
- Arrangement does not induce or reward referrals
- Documented in writing in advance or contemporaneous with the activity
- Remuneration must be paid within 6 months of closeout

Red Flags

- Inappropriate referrals
- Inducements to limit care
- Cherry Picking
- Payments tied to billables

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Beneficiary Engagement

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Beneficiary-Facing Materials & Activities

- Must be approved by CMS
  - 10-day file & use (business days)
  - Know when to trust the 10-day mark
  - Recommendation: create internal compliance approval and CMS submission process
  - ➢ Email CMS to tell them when you've submitted a material via the File Exchange
- Language Translation Requirements
  - Translation threshold: 5% of **aligned** beneficiaries

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Beneficiary Notifications

Annual Notification for all Aligned Beneficiaries

- Prospective Plus means quarterly “gap” notifications
- Must use CMS template without modifications.
  - May add your logos and a brief paragraph about the DCE
  - Must file each version with CMS.
  - Names and phone numbers can be filed as variable. Use <Name> and <Number> to indicate this field may change.

Considerations

- Method of Distribution: snail mail, e-mail, portal, in-office
  - Mail: CMS address vs EMR address
  - Email: Be aware of ‘unsubscribes’
  - Portal: Must ‘ping’ the beneficiary of the notification
  - In-Office: Audit trail is difficult to maintain, better back-up option after failed attempts
- Timeline to Drop
  - Leave adequate time for returned mail/undeliverable email processing
  - CMS requires 2 documented attempts to complete notification
- Documentation
  - Can’t just send it - have to prove it.
  - Proof at the individual beneficiary level (e.g., sent email, portal screenshot, mailing list provided to vendor.)
  - Returned mail: Scan returned mail and envelope

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Voluntary Alignment

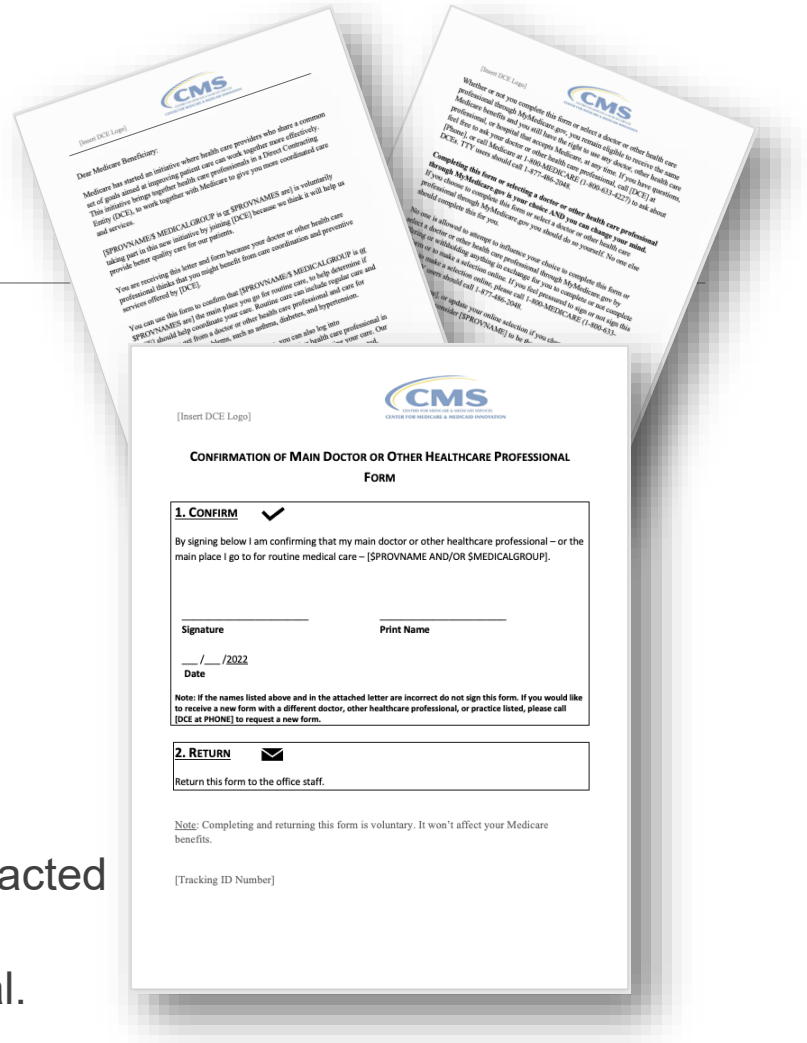
- Electronic Voluntary Alignment: MyMedicare.gov
  - Pros: No form collections, no PVA submissions
  - Cons: Medicare.gov is difficult to navigate and leads to lower response rates
- Paper-Based Voluntary Alignment
  - May be completed electronically (e.g., DocuSign)
  - Pros: Higher response rates
  - Cons: Documentation requirements, increased compliance risk

➢ Create detailed documentation about which beneficiaries are contacted and why.

➢ All materials and PVA Plan must be submitted to CMS for approval.

➢ Form cannot be sent with Beneficiary Notification.

➢ Outreach must be within DCE Service Area.


[Insert DCE Logo]

CONFIRMATION OF MAIN DOCTOR OR OTHER HEALTHCARE PROFESSIONAL FORM

1. CONFIRM

By signing below I am confirming that my main doctor or other healthcare professional – or the main place I go to for routine medical care – [$PROVNAME AND/OR $MEDICALGROUP].

Signature

Print Name

___/___/2022
Date

Note: If the names listed above and in the attached letter are incorrect do not sign this form. If you would like to receive a new form with a different doctor, other healthcare professional, or practice listed, please call [DCE at PHONE] to request a new form.

2. RETURN

Return this form to the office staff.

Note: Completing and returning this form is voluntary. It won't affect your Medicare benefits.

[Tracking ID Number]

Voluntary Alignment

Process Considerations

- Documentation Requirements ← Start HERE and work backwards
  - Form Distribution
  - Completed Form Storage (and any accompanying materials such as enveloped)
  - Conversations with Beneficiaries about *possible or actual reversal* of PVA
- Letter & Form Distribution
  - Postal Mail
    - Can't send outside DCE Service Area
  - Patient Portal or Email
    - Must provide 'opt-out'/unsubscribe option for future communication (except for in relation to Beneficiary Notification)
    - Intro content must be submitted and approved by CMS
  - In-Office
    - Requires additional training for individuals distributing, storing, and processing forms. This training should include do's & don'ts, red flags, and criteria for valid forms.
- Form Processing
  - Collection
  - Quarterly PVA Submission & Timeline
  - 10-year Storage Requirement

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Benefit Enhancements & Beneficiary Engagement Incentives

- Must be approved to implement a BE/BEI **prior to the start** of the Performance Year
  - September 30th: Deadline to elect BE/BEI & submit Implementation Plans for 2023.
  - **Does not obligate** you to implement BE/BEI during the PY
  - New Participants & Preferred Providers can be added to BE/BEI during the PY

- Utilize CMS Checklists to create Implementation Plan

- For actual Implementation of BE/BEI, start with the relevant Appendix & required documentation and build backwards.
  - Consider bottle necks in documentation
    - Bottle necks = Compliance Risk.
    - Example: Medical Director approval prior to referral under SNF 3-Day Waiver.

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Beneficiary Inducement Safe Harbor

- Does **not** require CMS approval.
- May be utilized any time during the PY.
- Allows the DCE/ACO to provide items or services if:
  - ❑ The DCE reasonably determines the incentive will advance one or more goals of the model;
  - ❑ The incentive has a direct connection to the patient's health care
  - ❑ The incentive is furnished by the DCE, Participant or Preferred Provider
  - ❑ Must be an in-kind items or services (no cash or cash equivalent)
  - ❑ The item must not be covered by Medicare (or a BE/BEI even if the DCE is not utilizing the BE/BEI)
  - ❑ Must not be linked to Voluntary Alignment

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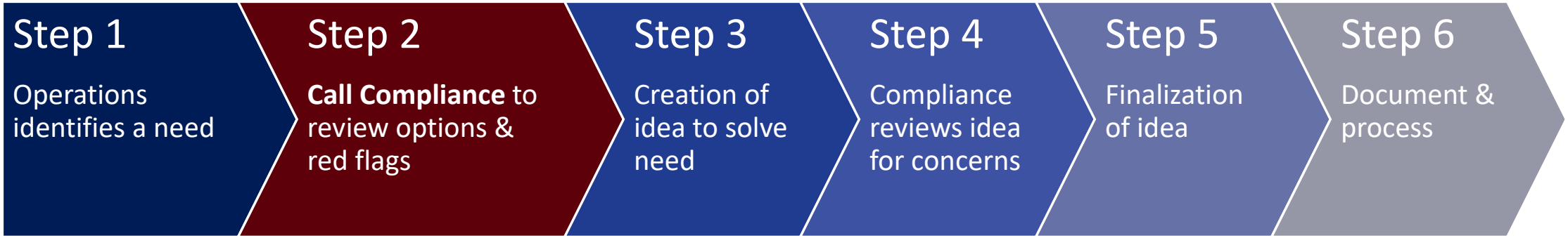
Key Take Away: Call Compliance



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Audit Preparedness

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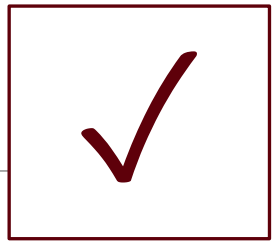
Written Arrangements Audit



- Complete for all DCEs during PY 2021 and all IP2 and PY2022 Starters in 2022
- Request for Information allowed approximately 5 weeks for response
- Sample of Participants & Preferred Providers
  - ✓ Executed Participation Agreement for that Provider
  - ✓ Executed Fee Reduction Agreement for that Provider
  - ✓ Participant Notification (individual provider level)
    - ✓ Do **not** rely on the practice to send
  - ✓ Documentation around any terminations of sampled providers, including submission to CMS
- Complete Participant & Preferred Provider Roster
- No request for TIN level Notification

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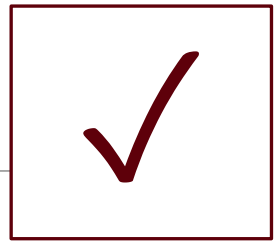
PVA Audit



- Not conducted in PY 2021. Conducted for all DCEs in 2022.
- Request for Information allowed approximately 3 weeks for response.
- Completed PVA Forms for a Sample of Beneficiaries (between 8 & 60)
- PVA Template Materials
- Marketing Plan
- PVA Policies, Scripts & Training Materials
- Documentation of Beneficiary Complaints related to PVA
- Documentation of Oral Communications with Beneficiaries related to a change in PVA
- Compliance Plan, Compliance Training
- Roster of Beneficiaries aligned through PVA

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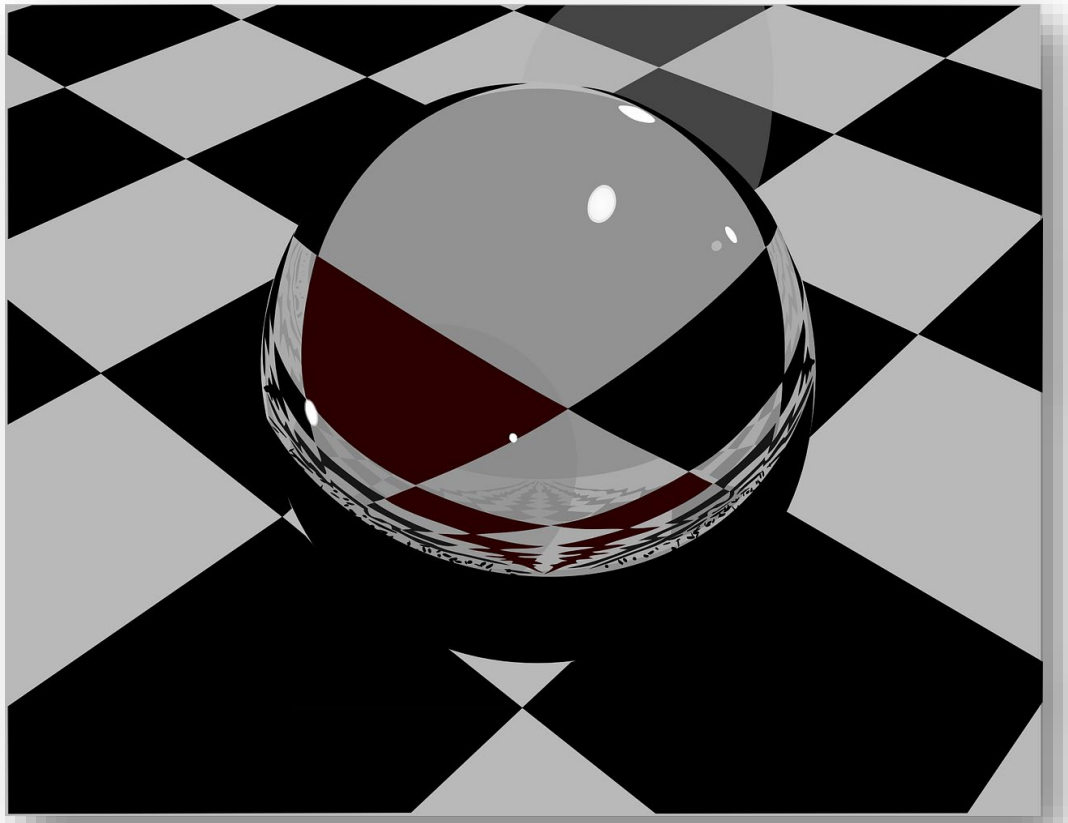
Crystal Ball



- Beneficiary Notifications
  - Mailing list with date and returned mail, email records, portal records
- Benefit Enhancements & Beneficiary Engagement Incentives
  - Check the appropriate appendix for record keeping requirements
  - Check your Implementation Plan
  - At a minimum, make sure you can document:
    - ❑ The Beneficiary name and identifier to detail who received an item/service under the BE/BEI
    - ❑ The date the item/service was furnished
    - ❑ Beneficiary Eligibility
    - ❑ The value of the item/service furnished under the BE/BEI

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ACO REACH Model

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ACO REACH – Annual CMS Validations

- Public Reporting
  - Governance
  - Leadership
  - Provider Rosters
  - Program Performance
  - Benefit Enhancements
- Financial Guarantee
  - Secure
  - Maintain
  - Update

- Benefit Enhancements & Beneficiary Engagement Incentives
  - Implementation Plans: Unclear whether this will require annual submission
  - Plan vs. Observed Use
- Use of CEHRT
- Beneficiary Alignment & Access to Care Patterns
  - Changes and trends in care, access, treatment, code and outcomes

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ACO REACH - Governance

	Participant Control	Med Bene Rep.	Med Bene Rep. Vote	Consumer Advocate	Consumer Advocate Vote	Med Bene Rep & Consumer Advocate are same person
MSSP	75% Med Bene Rep not included	**REQUIRED**	*OPTIONAL*	N/A	N/A	N/A
GPDC	25% Consumer Advocate/Med Bene Rep not included	**REQUIRED**	*OPTIONAL*	**REQUIRED**	*OPTIONAL*	*OPTIONAL*
REACH	75% all Members included	**REQUIRED**	**REQUIRED**	**REQUIRED**	**REQUIRED**	**NON-COMPLIANT**

ACO REACH – What's Next?

- Health Equity Plan: due early 2023, template coming Fall of 2022
- Nurse Practitioner Services Benefit Enhancements
  - Seeks to limit expenditures by allowing NPs to undertake certain activities to the extent permitted by state law
  - Certification for Hospice Care
  - Certification of Need for Diabetic Shoes
  - Certification of Care Plan for Cardiac Rehabilitation
  - Certification of Care Plan for Home Infusion Therapy
  - Referrals for Medicare Nutrition Therapy
- ? 90-day training requirement
- ? Tougher translation requirements

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