STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY24 ACCOUNTABLE CARE ORGANIZATION BUDGET ORDER

In re: Lore Health ACO LLC	)	
Fiscal Year 2024	)	
	)	Docket No. 23-002-A

INTRODUCTION

The Green Mountain Care Board (GMCB or Board) is charged with reviewing, modifying, and approving the budgets of accountable care organizations (ACOs). 18 V.S.A. § 9382(b). An ACO is an organization of health care providers that has a formal legal structure and agrees to be accountable for the quality, cost, and overall care of the patients assigned to it. *See* 18 V.S.A. § 9571. Below, we outline the legal framework for the Board's review of ACO budgets, identify the criteria we considered during our review of the FY24 budget of Lore Health ACO, LLC (Lore), and present specific Findings and Conclusions in support of our Order approving Lore's FY24 budget.

LEGAL FRAMEWORK

The ACO oversight statute and GMCB Rule 5.000 state that the Board will review, modify, and approve ACO budgets. *See* 18 V.S.A. § 9382(b), GMCB Rule 5.000, § 5.405(c). The Board's review of an ACO's budget differs depending on whether the ACO is projected to have more or less than 10,000 attributed lives in Vermont. 18 V.S.A. § 9382(b)(1)-(2). For ACOs such as Lore that are projected to have fewer than 10,000 attributed lives, "the Board may consider as many of the factors described in [18 V.S.A. § 9382(b)(1)] as the Board deems appropriate to [the] . . . ACO's size and scope." 18 V.S.A. § 9382(b)(2); GMCB Rule 5.000, § 5.405(c)(2). Considering the size and scope of Lore's operations in Vermont, the Board's review of Lore's FY24 budget focused on the following factors from 18 V.S.A. § 9382(b)(1):

- information regarding utilization of the health care services delivered by health care providers participating in the ACO and the effects of care models on appropriate utilization, including the provision of innovative services;
- the character, competence, fiscal responsibility, and soundness of the ACO and its principals;
- any reports from professional review organizations;
- the ACO's efforts to prevent duplication of high-quality services being provided efficiently and effectively by existing community-based providers in the same geographic area, as well as its integration of efforts with the Blueprint for Health and its regional care collaboratives;

- public comment on all aspects of the ACO's costs and use and on the ACO's proposed budget;
- information gathered from meetings with the ACO to review and discuss its proposed budget for the forthcoming fiscal year;
- information on the ACO's administrative costs, as defined by the Board;
- the extent to which the ACO makes its costs transparent and easy to understand so that patients are aware of the costs of the health care services they receive; and
- the extent to which the ACO provides resources to primary care practices to ensure that care coordination and community services, such as mental health and substance use disorder counseling that are provided by community health teams, are available to patients without imposing unreasonable burdens on primary care providers or on ACO member organizations.

GMCB PowerPoint, 25-26 (Dec. 6, 2023).

The Board's review of an ACO's budget must also consider any benchmarks the Board has established, as well as the elements of the ACO's Payer-specific programs and any applicable requirements of 18 V.S.A. § 9551 or the Vermont All-Payer Accountable Care Organization Model Agreement between the State of Vermont and the Centers for Medicare and Medicaid Services (CMS). *See* GMCB Rule 5.000, § 5.405(c).

Under statute, the Board's annual ACO budget review is separate from the Board's role in certifying ACOs. Certification is required for an ACO in Vermont to be "eligible to receive payments from Medicaid or commercial insurance through any payment reform program or initiative, including an all-payer model." *See* 18 V.S.A. § 9382(a).

FY24 REVIEW PROCESS

The review process for Lore's FY24 budget is reflected in the following timeline:

06.28.23: The Board issued FY24 budget guidance and reporting requirements for Medicare Only Non-Certified ACOs (Medicare-Only ACO Budget Guidance).
10.02.23: Lore submitted its proposed FY24 budget to the Board (Lore Budget Submission).
11.01.23: Lore presented its budget at a hearing before the Board (Lore Budget Presentation).
11.20.23: Board staff presented an analysis and preliminary recommendations regarding Lore's proposed FY24 budget (GMCB Staff Analysis I).
12.06.23: Board staff presented additional analysis and updated recommendations regarding Lore's proposed FY24 budget (GMCB Staff Analysis II), and the Board voted to approve Lore's FY24 budget on the terms and subject to the conditions described in this Order.

The written materials from this process are posted on the Board's website[1] and video recordings of the meetings are available on the Board's YouTube channel.[2]

[1] Written budget materials are available at https://gmcboard.vermont.gov/aco-oversight/FY24MedicareOnly. Board presentations are available at https://gmcboard.vermont.gov/2023-meetings.
[2] https://www.youtube.com/@GreenMountainCareBoard/videos.

FINDINGS

Overview

1. Lore Health ACO LLC ("Lore") is a Delaware limited liability company. Lore was previously named Gather Health ACO, LLC, but changed its name in November of 2022. *In re Lore Health ACO LLC Fiscal Year 2024*, 2021-002-A, FY24 Accountable Care Organization Budget Order, Findings of Fact (Findings), ¶ 1 (May 22, 2022).

2. 2024 will be Lore's second year participating in the Medicare Shared Savings Program (MSSP), which is run by the Centers for Medicare and Medicaid Services (CMS). *See* Lore Budget Submission, 2; GMCB Staff Analysis I, 7. 2024 will also be Lore's second year operating in Vermont. *See In re Lore Health ACO LLC Fiscal Year 2024,* 2021-002-A*,* FY24 Accountable Care Organization Budget Order (May 22, 2022). Within MSSP, Lore participates in the ENHANCED risk track, with higher levels of upside and downside risk. *See* Lore Budget Submission, 2, 8; Lore Budget Presentation, 7.

3. Lore's provider network spans five states, including Vermont, down from six in 2023. *See* GMCB Staff Analysis I, 7; Lore Budget Submission, 3.

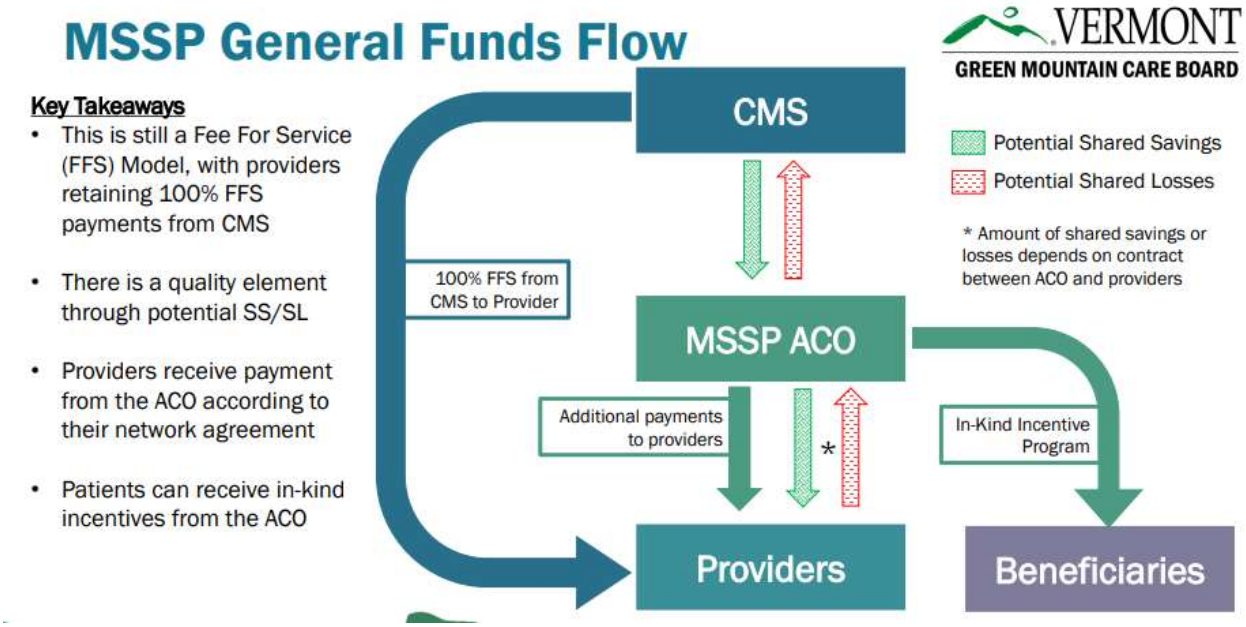
4. Lore anticipates having approximately 3,800 aligned Medicare beneficiaries in Vermont in FY24, with one Vermont provider organization in its network. *See* Lore Budget Submission, App. A-1; GMCB Staff Analysis I, 15. The Vermont provider organization in Lore's network, Springfield Medical Care Systems, Inc. (d/b/a North Star Health), is a federally qualified health center with locations in both Vermont and New Hampshire. *See* GMCB Staff Analysis I, 15. Lore's 12-member governing body includes two clinicians from this Vermont provider organization. *Id.* at 13; Lore Budget Presentation, 5.

5. Lore has no plan to expand its provider network in Vermont at this time, although it states that is open to Vermont providers that are aligned with its model of care. *See* Lore Budget Submission, 4; GMCB Staff Analysis I, 14.

Payer Program and Risk Model

6. MSSP is the only Payer program that Lore participates in. *See* Lore Budget Submission, App. B. The specific requirements for attribution to MSSP, which can be claims-based or voluntary, as well as the other parameters for participation in the program, are set by CMS. *See* GMCB Staff Analysis II, 3.

7. MSSP is a fee for service model, with CMS adjudicating claims and paying providers on a fee for service basis. *See* Staff Analysis I, 17. There is a potential for shared savings or shared losses based on Lore's performance, which would be paid between CMS and Lore. *See id*. Lore pays providers according to the terms of its network agreements with providers. *See id*. Lore may also provide in-kind incentives to beneficiaries. The general flow of payments in CMS's MSSP model is outlined below:



Id.

8. Medicare beneficiaries aligned to an MSSP ACO remain enrolled in traditional Medicare and have access to the same network of providers they would have access to if they were not aligned. *See* GMCB Staff Analysis I, 8-9. Alignment to an ACO also does not increase a beneficiary's out-of-pocket costs or premiums. *See id.* at 8.

9. CMS sets total cost of care benchmarks for ACOs participating in MSSP using trended, risk-adjusted historic spending. *See* Lore Budget Submission, 4. The benchmarks are set prospectively and cover all Medicare Part A and Part B expenditures. *See id*.

10. MSSP utilizes risk corridors (i.e., limits on an ACO's shared savings and shared losses), which are established by CMS. *See* Lore Budget Presentation, 8; GMCB Staff Analysis I, 18. Having elected MSSP's ENHANCED risk track, Lore will be eligible to earn first dollar savings at a shared savings rate of 75%, provided a minimum savings rate of 0.5% is exceeded. Lore's maximum potential shared savings will be equal to 20% of the total benchmark (i.e., the overall spending target). Lore may also be liable for first dollar losses at a rate of between 40% and 75% based on its quality performance, provided a minimum loss rate of 0.5% is exceeded. Lore's maximum potential shared losses will be equal to 15% of the total benchmark. *See* Lore Budget Submission, 4, 8, App. B; GMCB Staff Analysis I, 18.

11. [redacted]

12. As part of MSSP, ACOs must establish a repayment mechanism in an amount set by CMS. Lore has established a repayment mechanism in accordance with CMS regulations that will

allow CMS to collect the specified amount in the event Lore becomes liable to CMS for shared losses. *See* Lore Budget Submission, 8.

13. In MSSP, CMS truncates claims experience at the 99th percentile in its calculation of an ACO's benchmark and its calculation of the ACO's performance. By removing the top 1% of claims, the ACO's risk reflects less catastrophic claims expense and more of a standardized distribution. *See* Lore Budget Submission, 8.

14. The Enhanced track of MSSP is considered an Advanced Alternative Payment Model (APM) under CMS's Quality Payment Program, allowing participating providers to seek Qualifying APM Participant (QP) status based on their levels of payments or patients through the Advanced APM. *See* Alternative Payment Models in the Quality Payment Program as of December 2022.[3]

Financials (Revenues and Expenses)

15. As FY23 is Lore's first year of operation, it does not have past results or financials. *See* Lore Budget Submission, 6. Lore will know its final 2023 financial and quality results in the second half of 2024. *Id.*; GMCB Staff Analysis I, 21.

16. Lore provided projected financials for its Vermont operations as part of its budget submission. These financials do not anticipate any payments from Vermont providers or Vermont aligned beneficiaries to Lore. *See* Lore Budget Submission, 7, App. C.

Model of Care

17. Lore is focused on the practice of lifestyle medicine to improve the health of Medicare beneficiaries. *See* GMCB Staff Analysis I, 26.

18. Lore relies on the use of a beneficiary-facing mobile application or platform through which it seeks to educate patients and enable them to be their own agents of change. GMCB Staff Analysis I, 26.

19. To reduce chronic disease burdens and target addressable social determinants of health, Lore incorporates "in-kind" incentives for items and services that are not covered by Medicare. Lore states that the set of in-kind incentives it makes available to patients are evidence-based and enable the person to better understand and have greater agency for their health. *See* Lore Budget Submission, 9. An example of an in-kind incentive that Lore provides is a home-based test for kidney function. *See* Testimony of Mark Briesacher, Lore Budget Hearing Transcript, 31:9 – 33:3. Lore's mobile application is also an in-kind incentive. *See* Testimony of Mark Attala, Lore Budget Hearing Transcript, 43:17-19.

20. Lore states that it tracks high and low utilization of services as part of on-going analytics and gives its participating providers information on attributed beneficiaries, such as

[3] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2180/2022%20and%202023%20Comprehensive%20List%20of%20APMs.pdf.

information on utilization-to-date, hospitalizations, and emergency department visits. *See* Lore Budget Submission, 10.

21. MSSP ACOs may take advantage of certain waivers of Medicare payment rules. For 2024, Lore has applied to CMS for a waiver of the Skilled Nursing Facility 3-Day Rule, which requires a Medicare beneficiary to have an inpatient hospital stay of at least three days before Medicare will cover skilled nursing facility services. Lore hopes that utilization of the waiver will improve patient quality of care through reduced utilization of emergency department and inpatient hospital services. *See* Lore Budget Submission, 9. Lore will partner with skilled nursing facilities in Rutland, Vermont to implement the waiver, should it be approved by CMS. *See* Testimony of Mark Atalla, Lore Budget Hearing Transcript, 19:13 - 23. Lore plans to have conversations with other skilled nursing facilities in Vermont in 2024. Testimony of Mark Briesacher, Lore Budget Hearing Transcript, 29:25 – 30:4.

22. Lore reports no specific care coordination initiatives and no integration with community-based providers other than its implementation of the Skilled Nursing Facility 3-Day Rule. However, North Star Health participates in Vermont's Blueprint for Health. GMCB Staff Analysis I, 24.

23. Lore states that its care model and approach to population health align with CMS's and the Vermont Blueprint for Health's focus on health equity and addressing social determinants of health, supporting patients' management of chronic diseases, helping patients understand resources available to them, and enhancing their experience with the care system. Lore Budget Submission, 9; *see also* GMCB Staff Analysis I, 23.

Data Collection and Use

24. Lore has previously stated that it will not sell or share any beneficiary data that it collects. *See In re Lore Health ACO LLC Fiscal Year 2024*, 2021-002-A, FY24 Accountable Care Organization Budget Order, Findings, ¶ 16 (May 22, 2022).

Integration with Vermont All-Payer Model Initiative

25. Providers that participate in MSSP cannot participate in other Medicare ACO initiatives, which means they cannot participate in Vermont's Medicare ACO Initiative. *See In re Lore Health ACO LLC Fiscal Year 2024*, 2021-002-A, FY24 Accountable Care Organization Budget Order, Findings, ¶ 17 (May 22, 2022).

Public Comments

26. The Board received comments and recommendations on Lore's proposed budget from the Office of the Health Care Advocate (HCA) pursuant to 18 V.S.A. § 9382(b)(3)(A). In its comments, the HCA expressed concern about a lack of evidence regarding the efficacy of Lore's model of care, a lack of transparency, and Lore's profit motive. The HCA recommended that the Board require Lore to submit financial and quality reporting annually, establish deadlines for confidentiality requests in future budget guidance, and

expand the scope of its authority over Medicare-only ACOs such as Lore. *See* Staff Analysis II, 5.

CONCLUSIONS

Under 18 V.S.A. § 9382, the GMCB's regulatory role for an ACO like Lore that only participates in a Medicare program is not to approve or deny the ACO's operation in Vermont; the GMCB's role is to approve or modify a proposed budget for the ACO for each year the ACO elects to operate in Vermont. Lore bears the burden of justifying its proposed budget. Rule 5.000, § 5.405(a). In deciding whether to approve or modify the budget, the Board may consider as many of the criteria of 18 V.S.A. § 9382(b) as the Board deems appropriate to Lore's size and scope. Because of Lore's limited size in Vermont, with only around 3,800 Vermont beneficiaries projected to be aligned in 2024, because Lore is a relatively new entrant in Vermont with no MSSP performance to review and no specific plans to expand, and because the programmatic elements of much of Lore's model are established by CMS, the Board focused its review on the factors set out in the Legal Framework. *See* Findings, ¶¶ 2-6, 16.

Beneficiaries aligned to Lore will remain enrolled in traditional Medicare and will have access to the same network of providers they would have access to if they were not aligned. Findings, ¶ 8. Alignment will also not increase beneficiaries' out-of-pocket costs or premiums. *Id.*

Lore is still a relatively new entrant in Vermont. *See* Findings, ¶ 2. We conclude that it is appropriate to focus on collecting information about Lore's quality and financial performance to help establish a baseline for Lore's operations in the state. All reporting will be done in a way that ensures patient confidentiality is protected, in light of the small number of aligned beneficiaries. To that end, we include conditions for Lore to report its shared savings or losses and its quality results for Vermont. Also, recognizing that FY23 is Lore's first year of operations in Vermont, we include conditions for Lore to provide an updated financial summary, including a breakout for in-kind incentive spending, using a template that GMCB staff design for that purpose. We also require Lore to provide a semi-annual update regarding how its model of care is working in Vermont, including any consumer complaints. Finally, we require Lore to engage in an orientation of the Blueprint for Health to prevent duplication of efforts with that program or promote possible integration.

ORDER

Based on our Findings and Conclusions above, and pursuant to 18 V.S.A. § 9382, we hereby approve Lore's FY24 budget as submitted and subject to the conditions set forth below:

1. Lore shall provide to GMCB Lore's FY24 shared savings/losses, segmented for Vermont.

2. Lore shall provide to GMCB an updated version of its Vermont financial summary with actuals, including a breakout for in-kind incentive spending. GMCB staff is delegated responsibility to develop an appropriate template and set the submission deadline.

3. Lore shall provide to GMCB Lore's MSSP quality reporting, segmented for Vermont if possible, with appropriate restrictions to protect patient confidentiality.

4. Following three performance years in Vermont, Lore shall provide to GMCB reporting for those years on GMCB-specified metrics, which may include the categories of inpatient medical, inpatient surgical, emergency department, professional office visits, ambulatory sensitive admissions, and any additional metrics. GMCB staff is delegated responsibility to develop templates and metrics and set deadlines for this reporting.

5. Lore shall provide a semi-annual update about how Lore's care model is working in Vermont, including any consumer complaints (not limited to Vermont beneficiaries). The development of the report template and the deadlines for submission are delegated to GMCB staff.

6. A representative from Lore must engage in an orientation led by Blueprint for Health within the first quarter of 2024.

7. After notice and an opportunity to be heard, the GMCB may make such further orders as are necessary to carry out the purposes of this Order and 18 V.S.A. § 9382.

So ordered.

Dated: January 17, 2024 at Montpelier, Vermont

s/ Owen Foster, Chair)
)
s/ Jessica Holmes) GREEN MOUNTAIN
) CARE BOARD
s/ Robin Lunge) OF VERMONT
)
s/ David Murman)
)
s/ Thom Walsh)

Filed: January 17, 2024

Attest: s/ Jean Stetter
Green Mountain Care Board
Administrative Services Director

NOTICE TO READERS: This document is subject to revision of technical errors. Readers are requested to notify the Board (by e-mail, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made.