VERMONT
GREEN MOUNTAIN CARE BOARD

144 State Street
Montpelier, VT 05633-3601
802-828-2177

2025 Budget Guidance and Reporting Requirements for Medicare-Only Accountable Care Organizations

Prepared by:

GREEN MOUNTAIN CARE BOARD

144 State Street

Montpelier, Vermont 05602

BACKGROUND

This guidance, adopted by the Green Mountain Care Board (GMCB), serves as the GMCB's Annual Reporting and Budget Guidance for Budget Year 2025 for any Accountable Care Organization (ACO) that (i) is not certified by the GMCB, and (ii) is participating only with Medicare and not Medicaid or any commercial payers. See 18 V.S.A. § 9382(b) and GMCB Rule 5.000, §§ 5.403, 5.405(c). ACOs that wish to receive payments from Vermont Medicaid or a commercial insurer must, in addition to having their budgets approved, be certified by the GMCB. See 18 V.S.A. § 9382(a). For more information about certification, please contact GMCB. In accordance with 18 V.S.A. § 9382(b)(3)(A) and GMCB Rule 5.000, §§ 5.105, 5.404(b), the Office of the Health Care Advocate (HCA), which represents the interests of Vermont health care consumers, must receive ACO budget filings and other materials and shall have the right to participate in the budget review process, including hearings.

2024 TIMELINE FOR 2025 BUDGET SUBMISSION (subject to change)

October 1, 2024:	ACOs submit budgets to GMCB
November 2024:	ACOs present budgets to GMCB at a public meeting
December 2024:	GMCB staff presents analyses to GMCB
December 2024:	Public comment closes when GMCB votes
December 2024:	GMCB votes on the ACOs' budgets and reporting submission at a public meeting
February 2025:	GMCB issues written orders to ACOs

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CONFIDENTIAL

The Green Mountain Care Board's Accountable Care Organization Budget Guidance - 2025

Instructions

Please answer all questions in this Guidance. For ACOs that are not taking the risk of losses, please mark any question that relates to shared risk with "N/A" or similar response. References to attributed lives, providers, provider network, and payments or spending are limited to the ACO's metrics for the State of Vermont, unless otherwise specified. If a response is not specific to the ACO's Vermont business, it must be noted.

An ACO may respond to questions in this Guidance by incorporating by reference publicly available information maintained or filed by the ACO. If the ACO wishes to incorporate any such public information, a link to a publicly accessible website or other publicly accessible filing must be provided, along with a specific reference to the location (section number, page number, or other appropriate reference) where the required information can be found within the link. Furthermore, submission should not include links to any documents that are not publicly available (e.g. Dropbox, Google Drive).

If the ACO believes materials it provides to the GMCB during this process are exempt from public inspection and copying, **the ACO must submit a written request** asking the GMCB to treat the materials accordingly. The written request must specifically identify the materials the ACO claims are exempt from disclosure under 1 V.S.A. § 317(c); provide a detailed explanation citing appropriate legal authority to support the claim; and comply with all other requirements set forth in GMCB Rule 5.000, § 5.106(c). The information for which the ACO seeks confidential treatment must be submitted in separate email with "Confidential" in the subject line. The document itself must include the word "Confidential" in the file name (if electronic) and on the face of the document, in a conspicuous location. The ACO must also include a redacted version of the document and include the word "Redacted" in the file name (if electronic) and on the face of the document, in a conspicuous location. When redacting information, the ACO must obscure the relevant information in the document either by using the applicable application's redaction tool or by otherwise blocking or covering the relevant information, or by deleting the relevant text and replacing with the word "REDACTED." The ACO may not redact information simply by deleting text or cells it has marked as confidential. It is the ACO's responsibility to ensure that information it has redacted matches the information separately marked as confidential. For more information on confidentiality and sample documents, please visit our website.

The GMCB recommends that the ACO submit the confidentiality request at the same time it submits the materials it considers confidential (or at least notify the GMCB of the confidential nature of the documents), but in any event, the written request must be submitted to the GMCB no later than three (3) days after the potentially confidential information is submitted to the GMCB. The HCA must be copied on all confidentiality requests and related submissions.

The HCA is bound to respect the GMCB's confidentiality designations and treat the submitted materials as confidential pending the GMCB's final decision on the request. See 18 V.S.A. § 9382(b)(3)(B); Rule 5.000, § 5.106(e)-(g).

Along with its responses to this Guidance, the ACO must submit a Verification Under Oath (on forms provided by the GMCB) signed by an officer of the ACO with responsibility for such matters. See 18 V.S.A. § 9374(i) and (j).

Submissions should be sent to: GMCB.ACO@vermont.gov and HCAPolicyTeam@vtlegalaid.org.

Section 1: ACO INFORMATION, BACKGROUND AND GOVERNANCE

1. Date of Application: **September 30, 2024**

2. Name of ACO: **Aledade Accountable Care 205, LLC**

3. Tax ID Number: [redacted]

4. Identify and describe the ACO and its governing body, including:
   a. Legal status of the ACO (e.g., corporation, partnership, not-for-profit, LLC): **Aledade Accountable Care 205, LLC ("AAC205" or the "ACO") is a limited liability company incorporated in Delaware, with Aledade, Inc. ("Aledade") as the sole member.**
   b. In which Medicare Program and track the ACO is participating: **The ACO participates in a Medicare Shared Savings Program (MSSP) Enhanced Track.**
   c. Members of the governing body and their organizational affiliation (and identifying the designated Beneficiary member of the governing body and the Consumer Advocate): **The ACO's governing body is comprised of 13 Board Members, 1 Medicare Beneficiary Representative, and 1 Aledade Representative (Market President):**

      1. **Melissa Buddensee–Ammonoosuc Community Health Services**
      2. **Ed Shanshala–Ammonoosuc Community Health Services**
      3. **Scott Soucy–Catholic Medical Center**
      4. **Paul H Deutsch–Deutsch Paul Office**
      5. **Jasdeep Sidana–DOCS Medical Group**
      6. **Akinyele Lovelace–Family Medicine Associates**
      7. **Kathryn Galbraith–Galbraith Family Medicine**
      8. **Raymond Shih–Haverhill Family Office**
      9. **Piyush Gupta–Internal Medicine of West haven**
      10. **Michael Kelly–Michael Kelly MD (Salisbury Primary Care)**
      11. **Sumita Mazumdar–Poughkeepsie Medical Group Llp**
      12. **Wayne Chen–Prime Healthcare**
      13. **Philip Karanian–Prime Healthcare**
      14. **Mark Hare–Medicare Beneficiary/Consumer Advocate**
      15. **Krista Sperry–Market President (tiebreaker vote)**

   d. Officers of the ACO: **The ACO's officers include:**

      1. **Medical Director: Dr. Akinyele Lovelace – Family Medicine Associates**
      2. **Compliance Director: Kelton George (Lead-Compliance)**
      3. **Market President: Krista Sperry**

   e. Committee and subcommittee structure of the governing body, as applicable: **The ACO's governing body is supported by a Compliance committee, which is composed of 4 members:**

1. **Kay Scott (Lead-Compliance)**
2. **Kelton George (Lead-Compliance)**
3. **Jillyan Bacallao (Lead-Compliance)**
4. **Janea Rudder (Compliance Coordinator)**

f. Description of governing body's voting rules; (*See* Rule § 5.403(a)1, 18 V.S.A. § 9382(b)1(d))

Each member of the governing body holds one vote, and approvals by the governing body follow a majority standard. The Aledade Representative–Krista Sperry–only votes in the event of a tie.

g. List of reserved powers that are reserved to the owner, member, or sponsoring organization or that require approval by a subset of ACO board members

The sole member of the ACO is authorized to appoint and remove members of the governing body.

The governing body will be responsible for: (a) the oversight and strategic direction of the ACO; (b) holding ACO management accountable for the ACO's activities as described in the MSSP Rules; (c) considering and approving compliance related policies; (d) oversight of the ACO's long and short term strategies; (e) the development of processes to promote evidence-based medicine and patient engagement; (f) considering and approving reports to CMS on quality and cost measures; (g) the creation of Committees consistent with its responsibilities, and the appointment of ACO Suppliers to serve on those Committees and permanent Committees; and (h) the development and oversight of the overall coordination of care between ACO Suppliers and their Physicians. All other powers and responsibilities of the Company, including without limitation entering into any services agreement or loan agreement or accepting any capital contribution from Member, will be exercised solely by the Member.

5. Describe the ACO's consumer input activities including any information regarding a consumer advisory board including charter and membership (*See* Rule § 5.403(a)5)

The ACO has a Medicare beneficiary representative appointed to the governing body that will be a regular member of the board of managers, and will have the same rights, responsibilities and fiduciary duties as each other member of the governing body. They will also have opportunities to provide feedback on beneficiary-facing materials and services that would not normally rise to the board level. This allows for the representative to have oversight of the affairs of the ACO and actively participate in the governing body, which ensures that providers participating in the ACO prioritize patient experience and care quality as defined by the patient.

Aledade is also part of a NAACOS and Health Care Transformation Task Force joint committee on patient engagement and a major topic of discussion and work is the topic of

engaging beneficiaries serving on the ACO's board. Four national consumer and patient advocacy groups are part of this Committee and have provided significant input on setting beneficiaries up for success as they serve and engage on ACO boards. At Aledade, we have collected best practices and have educational materials for our ACOs and are continuing our learnings through this committee.

6. Describe the ACO's complaint, grievance, and appeal processes for providers and patients. (*See* Rule § 5.403(a)7)

   The ACO Participation Agreement sets forth the dispute resolution process for participating providers who dispute shared savings received pursuant to the Agreement.

   The Aledade Business Conduct Hotline is available to all ACO Board Members and ACO practices to report issues or concerns related to the ACO such as:

   - **Violations of ACO Code of Conduct, Compliance Plan or policies.**
   - **Conflicts of Interest; Issues that may impact the ACO and Medicare Shared Savings**

   The hotline allows for anonymous reporting and is available 24 hours a day. Concerns can be submitted by phone or online.

7. Describe any material pending legal actions taken against the ACO or its affiliates, any members of the ACO's executive leadership team or Board of Directors related to their duties. Describe any such actions known to be contemplated by government authorities including any compliance issues. (*See* Rule § 5.403(a)6, 18 V.S.A. § 9382(b)1(d))

   On March 25, 2021, a lawsuit was filed against Aledade, Inc. in federal district court for the Western District of Washington. The complaint was originally filed under seal pursuant to the qui tam provisions of the False Claims Act. On January 10, 2024, following a declination of intervention in the action by the Department of Justice, the complaint (which had since been amended in May 2022) was publicly filed. The complaint was served on the company on April 8, 2024; and subsequently amended on August 1, 2024, in order to remove all False Claims Act counts, narrowing the complaint to employment-related retaliation and wrongful discharge claims. Aledade intends to vigorously defend itself in response to this employment-based lawsuit.

8. With respect to the ACO's executive leadership team or Board members, describe any legal, administrative, regulatory, or other findings indicating a wrongful action involving or affecting the performance of their duties, or professional fiscal irresponsibility. (*See* Rule § 5.403(a)6, 18 V.S.A. § 9382(b)1(d))

   None.

9. If the ACO has been the subject of any reports from professional review organizations or payers, please attach said reports. (*See* Rule § 5.403(a)15, 18 V.S.A. § 9382(b)1(e))

   Not Applicable.

Section 2: ACO PROVIDER NETWORK

1. With respect to the ACO's provider network in Vermont, complete **Appendix A-1 – ACO Provider Network Summary Template** and, in the box starting on row 25, provide a brief narrative summary of each payment model that the ACO identified in **Appendix A-1**, column K, that the ACO utilizes in its provider network. (*See* Rule § 5.403(a)8)

   Please see attached.

2. How many other states will the ACO operate in for 2025? Please list the other states. (*See* Rule § 5.403(a)8)

   The ACO operates in Maine, New Hampshire, Massachusetts, New York, Connecticut, as well as Vermont.

3. What percentage of the ACO's attributed lives for 2025 will be in Vermont? (*See* Rule § 5.403(a)8)

   [redacted]

4. For ACOs that were operating in Vermont prior to 2025, complete **Appendix A-2** to quantify the number and type of providers that have dropped out of the network for all applicable years that the ACO was operating in Vermont, and to the best of your knowledge, their reasons for exiting; (*See* Rule § 5.403(a)8)

   Not applicable. The ACO did not operate in Vermont prior to 2025.

5. Does the ACO have plans to expand their provider network in Vermont in the next three years? (yes/no) (*See* Rule § 5.403(a)9)

   Yes.

6. For all provider contract types for which the provider is assuming risk, describe the ACO's current contract with the provider:
   a. The percentage of downside risk assumed by the provider, if any: **0%**
   b. The cap on downside risk assumed by the provider, if any, and: **0%**
   c. What risk mitigation requirements does the ACO place on providers, if any (e.g., reinsurance, reserves). (*See* Rule § 5.403(a)9): **None.**
   d. The amount of any withhold revenue for each provider: **None.**

   The ACO assumes all downside risk for all of our participating practices.

7. Submit the template of the ACO's provider contract(s) to GMCB. (*See* Rule § 5.403(a)9)

   Please see attached.

Section 3: ACO PAYER PROGRAMS

1. Provide the most recent annual ACO quality reports for all measures included in agreements with CMS. To the extent practicable, please provide segmented reports for Vermont operations.

   2024 ACO Required Measure Set. The ACO's first performance year is 2024— as a result, we do not have any historical results at this time.

2. Provide copies of existing agreements or contracts with Medicare governing the ACOs in the applicable Medicare program, including the participation agreement and any amendments. If 2025 contract is not available, please submit as an addendum when signed. (*See* Rule § 5.403(a)10)

   Please see attached.

3. Provide a completed Appendix B – 2025 ACO Program Arrangements and Elements (*See* Rule § 5.403(a)2, (a)10, (a)11, (b)1)

   Please see attached.

3. Describe proposed categories of services included for determination of the ACO's savings or losses, if applicable, and if possible, projected revenues by category of service and type of payment model (e.g., FFS, capitation, or AIPBP). (*See* Rule § 5.403(a)9, (a)10)

   The Medicare Shared Savings program includes fee-for-service (FFS) spending for covered Medicare Parts A and B FFS claims from all of the following: inpatient, Skilled Nursing Facility (SNF), outpatient, Home Health Agency (HHA), and hospice claims at any provider, line-item payment amounts identified for carrier (including physician/supplier Part B) and Durable Medical Equipment (DME) claims.

4. Describe how the proposed ACO benchmark, capitation payment, AIPBP, shared savings and losses, or any other financial incentive program are tied to quality of care, patient satisfaction, or health of aligned beneficiaries. (*See* Rule § 5.403(a)11)

   The ACO operates within the MSSP. MSSP has several requirements that tie the benchmark to shared savings and losses, quality of care, and patient satisfaction:

   For each performance year of the agreement period, ACOs share in a percentage of the savings they generate if the expenditures of the ACO's assigned beneficiaries are below their benchmark (i.e., their unique targets) by an amount that meets or exceeds a minimum savings rate threshold, and if they meet the quality performance standard or the alternative quality performance standard and otherwise maintain their eligibility to participate in the Shared Savings Program. ACOs participating in a two-sided model must also pay CMS a percentage of shared losses if expenditures for the ACO's assigned beneficiaries for the performance year exceeds their benchmark by an amount that meets or exceeds a minimum loss rate threshold.

MSSP ACOs are required to report quality data via the Alternative Payment Model (APM) Performance Pathway (APP) to meet the quality performance standard used to determine shared savings and shared losses. The quality performance standard is the minimum quality performance ACOs must achieve to be eligible to share in savings at the maximum rate available for the ACO's track. Meeting the quality performance standard also allows an ACO to avoid maximum shared losses for ACOs participating in the ENHANCED track. For Performance Year (PY) 2024 (*CMS has not finalized the PFS 2025 rule at this time)*, ACOs that report quality data via the APP can meet the quality performance standard via one of three pathways:

• Achieving a health equity adjusted quality performance score1 that is equivalent to or higher than the 40th percentile across all Merit-based Incentive Payment System (MIPS) Quality performance category scores, excluding entities/providers eligible for facility based scoring.

• For ACOs reporting the 3 electronic clinical quality measures (eCQMs)/MIPS clinical quality measures (CQMs) and meeting the MIPS data completeness requirement for all 3 measures: Achieving a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least 1 of the 4 outcome measures in the APP measure set and a quality performance score equivalent to or higher than the 40th percentile of the performance benchmark on at least 1 of the remaining 5 measures in the APP measure set. Table 2 on page 3 of this document identifies APP measure types.

Section 4: ACO BUDGET AND FINANCIAL PLAN

1. Submit most recent audited financial statements and the most recent publicly available quarterly financial reports, or incorporate by reference to public filings with the Securities and Exchange Commission. Responses to this question do not need to be specific to Vermont operations. (*See* Rule § 5.403(a)2, (a)3)

   The ACO's first performance year is 2024. CMS will share 2024 performance year results and other ACO financial results in 2025.

2. Provide a description of the flow of funds between payer, ACO, provider, and patients using the below chart, include narrative descriptions in the "Notes" column for each row. Please also describe the ACO's business model. The description should indicate how the ACO expects to realize savings and should demonstrate the ability of the ACO to maintain sufficient funds to support its administrative operations and meet provider payment obligations. (*See* Rule § 5.403(a)1, (a)3; 18 V.S.A. § 9382(b)1(d))

Funds Flow

From	To	Payment Type (Funds)	Notes
CMS	ACO	MSSP Shared Savings	The ACO maintains the contract with CMS for all shared savings. In the event of shared savings, shared savings will flow from CMS to the ACO.
ACO	Participating Practices	MSSP Shared Savings	In the event of shared savings, the ACO will pay shared savings to the ACO providers at the contracted amount.

The ACO receives shared savings payments from CMS, which is split between the ACO and practices based upon contractual agreement.

3. If the ACO is taking risk of loss, provide a narrative explaining how the ACO would manage the financial liability for 2025 through the risk programs included in Part 3 should the ACO's losses equal i) 75% of maximum downside exposure, and ii) 100% of maximum downside exposure. As part of the narrative response, describe your full risk mitigation plan to cover this liability and the mitigation plan for any contracted providers to which risk is being delegated or with which risk is being shared. This response is to include, but is not limited to:
    a. Portion of the risk covered by reserves, collateral, or other liquid security whether established as a program contractual requirement or as part of the ACO's risk management plan;
    b. Portion of the risk delegated through fixed payment models to ACO-contracted providers;
    c. Portion of the risk covered by ACO providers through mechanisms other than fixed payment models (e.g., withholds, commitment to fund losses at annual settlement, etc.);
    d. Portion of the risk covered by reinsurance or through any other mechanism (please specify);
    e. Any risk management or financial solvency requirements imposed on the ACO by third-party health care payers under ACO program contracts appearing in Section 3; and
    f. Whether any and the amount of liability of the ACO could be passed along to providers in its network if the ACO failed to pay any obligation related to its assumed risk. (*See* Rule § 5.403(b)2, (b)3)

There are multiple risk mitigation mechanisms that are established at the CMS program level and the ACO level, as set forth below:

- **Repayment mechanism - Aledade uses a combination of escrow agreements, letters of credit, and surety bonds.**

- **MSR/MLR - The ACO has the ability to select a minimum savings rate and minimum loss rate. If savings / losses do not exceed the MSR/MLR rate, no payment is made in either direction.**
- **Truncation - CMS truncates claims expenses at the 99th percentile for each benchmark category (i.e. ESRD, Disabled, aged / dual, and aged / non-dual).**

In the event of shared losses, a demand letter will be issued by CMS against the ACO's established repayment mechanism. In the event the repayment mechanism amount is not sufficient to cover the total amount of shared losses by the ACO, the ACO will be required to repay any remaining balance using alternative funding source. Furthermore, the ACO may choose to cover the shared losses with alternative funds and not the established repayment mechanism.

4. Complete **Appendix C – Financials** for 2025 and all past years the ACO has operated in Vermont as actuals or estimates as necessary.

   Please see attached. The ACO did not operate in Vermont for 2023 or 2024.

   In addition to the Appendix, describe:
   a. The proportion of shared savings invested in infrastructure, operations, redesigned care processes, and other resources necessary to improve outcomes and reduce Medicare costs for beneficiaries on a total ACO-wide basis: [redacted]
   b. The proportion of shared savings distributed to providers on a total ACO-wide basis, with breakouts for different provider types if applicable. (*See* Rule § 5.403(a)2, (a)3; 18 V.S.A. § 9382(b)1(M)) [redacted]

5. Does the ACO have any executive leadership compensation structure that is tied to reducing the amount paid for patient care? (*See* Rule § 5.403(a)3; 18 V.S.A. § 9382(b)1(D), (b)1(M))

   No.

Section 5: ACO MODEL OF CARE AND COMMUNITY INTEGRATION

1. Describe the ACO's model of care, including the philosophy and evidence (such as peer reviewed studies, past performance, evidence based clinical pathways, etc.) that informs the ACO's model, programs, and processes. (*See* Rule § 5.403(a)11)

   The Applicant ACO, Aledade Accountable Care 205, LLC will be supported by Aledade, Inc. which partners with over 1,900 primary care physician practices, FQHCS, and RHCs across 45 states and many different types of contracts. We are committed to outcome-based payment models to improve the value of health care delivered to Medicare beneficiaries and other Americans. We are committed to using technology, data, practice-transformation expertise, and, most importantly, the relationship between a person and their primary care physician to improve the value of health care. Aledade has been participating in MSSP since 2014.

Each MSSP ACO, like Aledade Accountable Care 205, LLC, is a separate legal entity from Aledade, Inc. both to meet the requirements of the Medicare Shared Savings Program and to ensure that the physicians that make up the ACO guide and control the ACO. Aledade, Inc. supports the ACO with analytical services, technology, policy guidance, and financial support so that the physicians of the ACO and their practices can continually improve their knowledge and processes.

Aledade Accountable Care 205 will operate in Vermont with 4,241 lives under management. The goals of the ACO include improving patient outcomes including clinical quality (hypertension and diabetes control) and reduction of unnecessary hospitalizations, readmissions, and Emergency Department visits. Primarily these goals are met by surfacing actionable data to increase access to primary care and preventive services (Annual Wellness Visits, for example) through clinical transformation and workflow redesign. Improving accuracy and completeness of diagnosis coding and documentation helps these goals. By addressing the above, reduction in total cost of care should be achieved.

Aledade field teams work with each member practice in every ACO to help them achieve the complex goals of population health improvement through the Core 4 approach. Core 4 distills the work of value-based care into four targeted initiatives that further population health and increase the chance that a practice will earn shared savings and improve patient outcomes.

Aledade's population health approach is built on a foundation of a decade of experience from more than a thousand practices across the country in value-based contracts. We work with practices to prioritize care transitions (ED Follow up, post hospital & post SNF care), access and quality (ensuring patients have access to the practice including after hours to avoid urgent care and the ER, and focusing on wellness and prevention, and attribution and quality improvement metrics that are meaningful). We aim to align patients with the right clinical initiatives, according to their clinical diagnoses and burden of illness.

Aledade and every ACO we work with prioritizes Annual Wellness Visits (AWVs) and Transitional Care Management (TCM). We have years of data showing that AWVs are associated with lower overall healthcare costs and improved clinical care quality for patients. We published the first known study to estimate the association of AWVs with measures of cost and quality. Aledade demonstrates the value of primary care visits after discharge, having proven that post-ED and post-hospital visits reduce readmissions. Aledade practices outreach to and assess more than 80% of their patients after every hospital transitions, and consistently see two-thirds of their patients for follow-up after hospitalization. In 2023, 45% of eligible discharge events resulted in a TCM visit and an additional 14% of eligible discharges led to a non-TCM follow-up visit within 30 days.

Our care programs include high value referral management work as well as wraparound programs such as Comprehensive Advance Care Planning and kidney care management. A focus on health equity is a central consideration throughout every strategy. We need to find new ways to expand access to neighborhoods and communities who have historically lacked that access. We need to help patients who leave the hospital and face new challenges in their care

after an operation because of the condition of their home. We need to ensure that the highest risk patients, not just the patients who most frequently visit the doctor's office, are fully diagnosed and documented so we can give them the care they need. And finally, we need to ensure every patient can get access to the wraparound services and care they need in close coordination with their primary care doctor.

At Aledade, we take a patient centered approach in every outreach and patient engagement initiative we undergo with our member practices. Our population health tools ensure that practices are proactive with outreach and have an understanding of who is coming into the office and what needs to be addressed in the visit. For practices that opt in, Aledade can go further and offer services that help the practice extend their reach, through our Comprehensive Advance Care Planning, medication adherence initiatives, appointment scheduling, and asynchronous outreach that includes direct mail, text messaging, depending on patient preference, as well as materials practices can put in their offices. Aledade rigorously tests every patient outreach initiative, beyond process measures ("how many calls did we make?") to, "did we help change behavior" - did the patient make an appointment, refill a prescription, etc.

2. Describe how the ACO's model of care may incorporate each of the following efforts. Describe any other applicable efforts not listed:
    a. Any and all population health initiatives; (*See* Rule § 5.403(a)11)
        i. Describe the methods for prioritizing the initiatives;
        ii. List the major objectives for each initiative;
        iii. List the outcome measures and key performance indicators for each initiative;

The ACO works with our partner practices through tech-enabled services and practice transformation specialists. This is a three-prong approach. First, our Aledade app combines claims data, EHR data, ADT data, and in-house analytics to tell our partner practices who needs them now, give the care team a map of their health and health care services, and create a workflow to accomplish what patients need. Second, there is the Aledade Learning Center. All the training needed for population health is presented in all learning formats from videos, to presentations, to user guides. The Learning Center meets our partner practices where they are. Finally, and most crucially, practice transformation specialists. They are the coaches, translators, and problem-solvers that personally work with the practices to ensure success in the quadruple aim.

The ACO focuses on the following four initiatives which have been shown to improve health outcomes and reduce disparities for patients.

<u>Access & Quality:</u> true quality improvement means more than just satisfying performance metrics. It means maintaining a true connection to primary care where providers can conduct thorough assessments of patient risk factors while promoting discussions on wellness education

<u>Care Transitions:</u> helping patients through transitions between care settings leads to much higher patient satisfaction and reduces adverse, avoidable health care events. We

provide physicians with post-charge workflows that enable them to follow up with recently discharged patients

Risk Stratification: the alignment of patients to the right clinical initiatives according to their clinical diagnoses and burden of illness

Care Programs: we use data to help patients get the best care that complements the care they receive from their PCP. This includes high-value referral management as well as Comprehensive Advance Care Planning

The ACO leverages data from multiple sources to address health disparities. The primary sources are the Medicare enrollment information via CMS attribution files, 837s from practice billing systems, and by interfacing with our practice Electronic Health Records (EHRs). We also have a patient matching service that continually collects and updates any new demographic information we get for a patient including race, ethnicity and language. In areas where data is lacking we have teams that work with various payers and providers to optimize the data provided, including working on existing workflows to ensure missing data is captured in discrete fields to increase efficiency of data processing.

We are continuously trying to improve the acquisition and utilization of quality data. We measure our quality measures based on race and ethnicity and we include race and ethnicity in our risk models. We also leverage preferred language data to ensure linguistic appropriateness in patient engagement. Collecting beneficiary-reported demographic and social needs data can be challenging due to data interoperability limitations. However, we utilize our Annual Wellness Visits (AWVs) as an opportunity to update all pertinent information. It also provides an annual opportunity to improve record keeping in this area.

Aledade conducted a difference in difference cases study of our 2016 cohort of practice partners. https://doi.org/10.37765/ajac.2021.88747 Over a 4-year period, the cohort of ACOs is estimated to have prevented 10,917 hospitalizations, 19,338 emergency department visits, and 8859 skilled nursing facility visits, compared with the region. This is believed to be largely driven by improvements in care transitions and preventive care, such as annual wellness visits, which the cohort of ACOs performed at 265% above the regional average in 2019. By the end of 2019, costs were 13% lower than the regional comparison. Annual wellness visits were 265% above the regional average. Transitional care management was 194% higher, and primary care visits were 34% higher. Quality scores averaged 96% and 93% of patients rated their provider highly in CAHPS while reporting improved health and functional status.

b. Benefit enhancements or payment waivers offered; (*See* Rule § 5.403(a)11)

Not applicable.

c. How the ACO supports appropriate utilization of health care services by both providers and patients; (*See* Rule § 5.403(a)13; 18 V.S.A. § 9382(b)(1)(A))

AAC 205 participates in the MSSP. Within the MSSP, CMS enters into agreements with ACOs. ACOs facilitate coordination and cooperation among health care providers to improve the quality of care for Medicare fee-for-service (FFS) beneficiaries and reduce the rate of growth in expenditures under Medicare Parts A and B. For each performance year of the agreement period, ACOs share in a percentage of the savings they generate if the expenditures of the ACO's assigned beneficiaries are below their benchmark (i.e., their unique targets) by an amount that meets or exceeds a minimum savings rate threshold, and if they meet the quality performance standard or the alternative quality performance standard and otherwise maintain their eligibility to participate in the MSSP. ACOs participating in a two-sided model must also pay CMS a percentage of shared losses if expenditures for the ACO's assigned beneficiaries for the performance year exceeds their benchmark by an amount that meets or exceeds a minimum loss rate threshold.

d. How the ACO supports, assesses, and monitors coordination of care across the care continuum, including primary care, hospital inpatient and outpatient care, specialty medical care, post-acute care, mental health and substance abuse care, and disability and long-term services and supports, especially during care transitions; (*See* Rule § 5.403(a)18; 18 V.S.A. § 9382(b)(1)(H), (b)(1)(P))

The ACO leverages interdisciplinary care teams to coordinate care. We tailor workflows to leverage top-of-license work from administrative staff, nurses, medical assistants, primary care clinicians, pharmacists, and care managers. Outreach staff are trained to engage patients and bring them in for much needed annual wellness visits; clinical support staff leverage data from health information exchanges and direct connections to facilitate transitions of care upon discharge from the hospital or skilled nursing facility, or to re-embrace patients after they visit the emergency room. We use Medicare Part D data to prioritize patients for intervention from our pharmacy team and have facilitated medication management, medication adherence efforts, and high-value medication optimization. The ACO optimizes workflows within the practice for outreach and for data-driven intervention at the point of care.

Aledade launched Aledade Care Solutions (ACS), now Aledade Plus, to offer wraparound services to our member practices. These care teams will work closely with the ACO patient's practice, with documented care plan summaries and notes going directly in the practice's EHR. Care teams also host weekly meetings to round on patients and monthly operational meetings.

<u>Coordination of Care</u>
In Vermont and other states nationwide, Aledade processes more than 500,000 Admission, Discharge and Transfer notifications (ADT) per month for inpatient and emergency department events from 25 HIEs and 10 hospitals with an additional 12 HIE

connections in progress. At the close of 2021, Aledade received ADT notifications on 70% of all inpatient (IP) and emergency department (ED) discharges across its nationwide network.

We use the information received from ADT notifications to alert providers so that they may reach out to patients to schedule a Transitional Care Management (TCM) or other follow-up visits and address gaps in patient care as well as reduce the likelihood of a readmission. This workflow driven follow-up process has been integrated directly into the population health platform used by the providers Aledade partners with.

The ACO demonstrates the value of primary care visits after discharge, having proven that post-ED and post-hospital visits reduce readmissions. Aledade practices outreach to and assess more than 80% of their patients after every hospital transitions, and consistently sees two-thirds of their patients for follow-up after hospitalization. In 2023, 45% of eligible discharge events resulted in a TCM visit and an additional 14% of eligible discharges led to a non-TCM follow-up visit within 30 days.

Aledade's Integration Strategy team is working through data quality initiatives, with our data partners, to expand coverage in the post-acute market and to enhance processing of Observation Services throughout existing data channels.

<u>Behavioral Health</u>
Aledade works closely with every ACO to better integrate behavioral health in primary care. We work with two national vendors who provide integrated behavioral health via the Collaborative Care model, offering patients regular contact with a behavioral health care manager that is overseen by a psychiatrist and working in collaboration with the primary care physician, and we are working to expand this program. Every practice the ACO works with uses Aledade's educational materials on behavioral health, including our comprehensive Depression Toolkit, and have participated in multiple webinars covering various topics related to behavioral health and substance use disorders. Across all of our ACOs, 84% of patients were screened for depression with follow up provided for those who screened positive, and 72% of patients in Aledade ACOs had an Annual Wellness Visit which includes screening for alcohol and substance use disorders.

e. Participation and role of community-based providers (e.g., designated mental health agencies, specialized services agencies, area agencies on aging, home health services, community service organizations, and others) that are included in the ACO, including any proposed investments to expand community-based provider capacity and efforts to avoid duplication of existing resources; (*See* Rule § 5.403(a)16; 18 V.S.A. § 9382(b)(1)(F))

Aledade has used our providers' knowledge of their local communities and the ever increasing robustness of our population profile to go into the community and partner with community stakeholders such as a partnerships with a local grocery store chain that actually shows beneficiaries how to easily cook healthy foods rather than just telling beneficiaries they should eat healthier. These community partnerships have added

valuable collateral information to augment our clinical understanding of patient health needs, including how they are functioning in the community and whether existing services are sufficient.

We have also partnered with organizations to engage with our assigned beneficiaries to foster their ability to share in their medical decision-making, address their health needs, and to provide support for our beneficiaries and caregivers with chronic conditions. As happens everywhere with sicker than average populations, the fee for service payment system has attracted a staggering number of specialty providers and clinics who get more specialized and better at marketing every day. A trusted relationship with their primary care practice allows the beneficiary to have a place to turn to navigate this maze and avoid unnecessary health care services and evaluate the marketing claims they are bombarded with everyday.

We have begun collecting several case study examples of Aledade member ACOs partnering with community organizations to address health related social needs in this recent publication: https://aledade.com/value-based-care-resources/home/beyond-clinic-walls-how-acos-address-social-drivers-of-health/.

f. Integration efforts with the Vermont Blueprint for Health, regional care collaboratives and other state care coordination initiatives; (*See* Rule § 5.403(a)16; 18 V.S.A. § 9382(b)(1)(F))

The ACO will have access to Vermont HIE beginning PY2025. The ACO will integrate data from the HIE into our Aledade App and EMR overlay, allowing the ACO to identify ACO-attributed patients and specific care needs and to make patient outreach workflows close to real time and much more efficient.

g. Efforts that incentivize systemic health care investments in social determinants of health; (*See* Rule § 5.403(a)19) and

The ACO offers two virtual care programs to increase access to specialized support: Kidney Care Management (KCM) and Comprehensive Advanced Care Planning (CACP). These programs are designed to enhance patient care by providing targeted support and resources.

h. Efforts that incentivize addressing the impacts of adverse childhood experiences and other traumas. (*See* Rule § 5.403(a)20)

Not applicable.

3. Describe any strategies for expanding capacity in existing primary care practices, including but not limited to reducing administrative burden on such practices. (*See* Rule § 5.403(a)17)

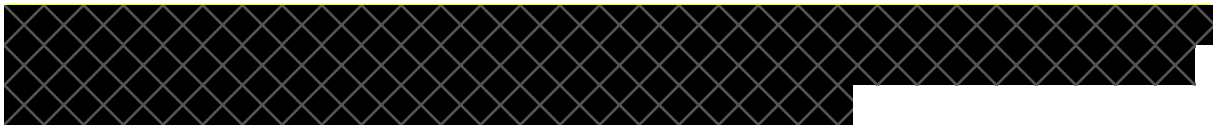
- **EHR optimization services are provided to practices to enhance visit templates, documentation and coding.**

- **Clinical engagement and operational strategy team will engage with practices to identify optimized workflows in pre-visit planning, quality measure surveillance and patient outreach.**

- **Clinical coaching on diagnosis documentation and provision of claims-level insights will be leveraged to support prioritization of clinical workflows that support improved morbidity and mortality of patient populations.**

- **The ACO has teams available to support with provision of additional supports for sub-populations that have higher risk for morbidity and mortality. Examples include kidney care management, assistance with providing comprehensive advance care planning, and the provision of remote patient monitoring**

- **Aledade continues to explore potential partnerships with remote scribing services, which can reduce administrative burden**

- 

4. Describe how the ACO, is addressing health equity? If the ACO has specific goals in this area, describe any specific actions the ACO is taking to achieve these goals. (*See* Rule § 5.403(a)22)

   As part of Aledade's mission to deliver better health, better care, and lower costs, the ACO is actively leveraging health equity in our processes, programs, and technology to create a more inclusive and equitable healthcare system that benefits all patients, practices, and society. To achieve these goals, we have taken specific actions such as establishing health equity partnerships with national payers to ensure patients are connecting to resources that address social drivers of health. We offer multilingual marketing vendor services to reach a broader patient base with cultural and linguistic inclusivity. Our Comprehensive Advance Care Planning and Kidney Care Management programs are intentionally designed to decrease disparities and increase health equity in the patient populations we serve. Additionally, we are expanding our health equity data analytics and our machine learning algorithms in our effort to continuously improve quality healthcare for all.

5. Describe the ACO initiatives addressing the items below. Specify objectives and include how the ACO will measure its performance over time. For additional information about the measures, please see Appendix 1 of the State of Vermont All-Payer ACO Model Agreement Extension.[1]

[1] *See page 51 of* State of Vermont All-Payer ACO Model Agreement Extension (Signed 2022), *available at* https://gmcboard.vermont.gov/document/amended-and-restated-vermont-all-payer-model-agreement-extension-signed-2022

a. Substance Use Disorder: reducing deaths from drug overdoses, increasing initiation and engagement of alcohol and drug dependence treatment, increase follow-up after discharge from the emergency department for alcohol or other drug dependence, reduce rate of growth of emergency department visits with a primary diagnosis of substance abuse condition, increase the utilization of Vermont's prescription drug monitoring program, and increase the number of Vermont residents receiving medication-assisted treatment (MAT) for substance use.

The ACO focuses on prevention and opportunities for intervention by recommending screening for substance use disorder (SUD) for Annual Wellness Visits. There are continued opportunities provided by the clinical engagement team for evidence-based updates on clinical practice and management, as well as clinical pharmacist team on hand. Locally, the New England Aledade team leverage the thought partnership of regional ACO practices to share community resources. Aledade engages in frequent collaboration with the National Association of CHCs and continues to lead in innovations for high risk populations.

b. Suicide: reduce the number of deaths due to suicide.

Behavioral Health is a chronic issue that is managed in primary care. The clinical engagement strategy includes extension curriculae surrounding behavioral health documentation.

c. Mental Health: increase follow-up care within 30 calendar days after discharge from a hospital emergency department for mental health, reduce rate of growth of emergency department visits with a primary diagnosis of mental health, increase screening for clinical depression (and if depression was detected, include a follow-up plan).

The ACO has a robust operational model, based on Admission-Discharge-Transfer feeds from local hospitals that helps coordinate Transitions of Care visits within 7 days of discharge. This is documented and monitored visit live feeds. We have similar insights with emergency room presentations.

The ACO also receives Emergency Department and Hospital Admission Data from CMS, which can be broken down by cost and diagnosis.

d. Chronic Conditions: decrease the prevalence and complications of COPD, diabetes, and hypertension for Vermont residents, reduce composite measure comprising of diabetes, hypertension, and multiple chronic condition morbidity.

Reduction of morbidity and mortality, as well as the unnecessary costs associated with poor care for chronic conditions is the cornerstone of physician-led accountable care organizations. The ACO supports the monitoring and evaluation of chronic conditions by providing robust coaching, chart review and providing insights by claims on accurate and complete documentation and coding at the point of care.

e. Access to Care: increase number of Vermont residents reporting that they have a personal doctor or primary care provider and increase percent of Vermont residents who say they are getting timely care, appointments, and information.

Access to Care is an increasingly important aspect of primary care and prevention. The ACO offers best practices to optimize scheduling, educate patients on proper use of the emergency and urgent care centers, as well as provide trust extensions of primary care office, in order to provide optimal care ambulatory services in the best way possible to patients who need it. Telehealth continues to be an area of education. The ACO has the ability to partner with local remote specialists in behavioral health service rendering, which allows greater access to care for behavioral health. Our care coordinating branch continues to strive for innovative ways to support patients at higher risk of morbidity and mortality with care coordination or added supports.

f. Tobacco Use and Cessation: increase percent of Vermont residents who are screened for tobacco use and who receive cessation counseling intervention.

This is a part of the annual wellness visit and education on CPT2 coding. As part of our value-based care model, providers complete annual wellness visits that incorporate screening and appropriate cessation follow-up.

g. Asthma: increase percent of Vermont residents who receive appropriate asthma medication management.

The ACO clinical engagement and pharmacy team has educational material on the treatment and care of asthma. The ACO is also able to follow claims-relevant feeds to identify if patients carry this diagnosis and notify partner practices through our Aledade app.

6. Please describe any referral program that the ACO employs to coordinate patient care, including home-based care providers and community-based providers. (*See* Rule § 5.403(a)18)

The ACO provides CACP (comprehensive advance care planning) services to individuals dealing with serious illness by empowering them to make and document their future goals so they can get the care they want if they are unable to speak for themselves. Iris (Aledade patient facing brand) ensures that an individual's plan for future medical care is consistent with their values, goals and preferences. This facilitates PCPs in providing the right care, at the right time, in the appropriate setting and ensuring the patient's wishes are followed.

Aledade has partnered with trusted kidney care management provider VillageHealth (a subsidiary of DaVita) to identify and provide chronic kidney disease 4 and 5 patients at a high risk of an unplanned dialysis transition with specialized care management, patient education, and care coordination services. This program includes access to a dedicated RN care team, connections to a nephrologist (if a patient is not already receiving nephrology care), coordination across the patient's providers (nephrologist and PCP), and education about the patient's condition. This program also supports patients in making informed choices as they

transition into renal failure (i.e., home peritoneal dialysis, in-center hemodialysis, or preemptive transplant).

The Aledade Plus Performance Scheduling Outreach Contact Center team provides short-term and intermittent, real-time support to practices facing patient outreach barriers or short-term staffing shortages. Our services encompass a range of outreach initiatives, including wellness outreach (AWV) and transitions of care (TOC) outreach.

7. Does the ACO benchmark performance measures against similar entities? If no, explain why not. If yes, what specific metrics does the ACO track and benchmark, what peer group(s) does the ACO use, and how does the ACO use the results? (*See* Rule § 5.403(a)22)

   The ACO uses utilization and quality benchmarks for the Medicare program, as well as ACO-specific data, to understand how the ACO is performing towards its objectives. For example, the ACO has domains in-patient and emergency utilization, blood pressure control, diabetes control, gaps in care, to name a few. The ACO also establishes benchmarks for engagement and how well the ACO and providers are connecting with assigned patients. Benchmarking is generally though not exclusively conducted against risk adjusted regional averages. "Region" being defined by the ACO's clinical service area.

8. Explain the ACO's quality evaluation and improvement program. Describe any improvement efforts the ACO focused on for FY25 and provide rationale for these efforts. (*See* Rule § 5.403(a)12)

   The ACO's focus on supporting high quality healthcare includes numerous ongoing, focused quality improvement efforts. These include, but are not limited to:
   - **Tracking Blood Pressure and Diabetes (A1c) in dashboards and alerting provers when patients are out range, and incentivizing medical practices for high quality care on these metrics.**
   - **Tracking rates Colorectal Cancer and Breast Cancer and support for scheduling these preventive services. Screening.**
   - **Notifying medical practices when patients need post-hospital and post-emergency department care, and supporting these visits.**

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Section 6: VERMONT ALL-PAYER ACCOUNTABLE CARE ORGANIZATION MODEL AGREEMENT SCALE TARGET ACO INITIATIVE

1. These tables seek to assist the GMCB in determining whether the ACO's payer contract meets the requirements of a Scale Target ACO Initiative (defined in Section 6.b of the All-Payer ACO Model Agreement). The GMCB may require additional information if required to satisfy the State of Vermont's reporting obligations under the All-Payer ACO Model Agreement.

Payer Contract: Click or tap here to enter text. **Contract Period**: Start Date to End Date **Date Signed**: Click or tap here to enter text.
Financial Arrangement – Shared Savings and/or Shared Risk Arrangements
Are shared savings possible? * **Yes**
Does shared savings arrangement meet minimum requirements of 30% of the difference between actual and expected spending (see Section 6.b of the All-Payer ACO Model Agreement)? * **Yes**
Describe shared savings and shared risk arrangement(s): The ACO is in the ENHANCED track of the Medicare Shared Savings Program.
Contract Reference(s): https://www.ecfr.gov/current/title-42/section-425.610
Payment Mechanisms – Payer/ACO Relationship
Describe payment mechanism(s) between payer and ACO (AIPBP, FFS, etc.): Shared Savings/Shared Losses for performance year expenditures compared to a weighted historical, trended, capped risk ratio adjusted benchmark.
Contract Reference(s): https://www.ecfr.gov/current/title-42/section-425.610
Payment Mechanisms – ACO/Provider Relationship
Describe payment mechanism(s) between ACO and ACO provider network: Please see contract template provided.
ACO Provider Agreement Reference(s): Section 3.4
For payments to providers, please complete the table below, identifying the applicable category of the payments (or percentage of payments in each category) based on HCP-LAN categories:

HCP-LAN Category	ACO / provider arrangements	$ value
Category 1: FFS-No link to Quality and Value		
1: FFS-No link to Quality & Value	None	0%
Category 2: FFS-Link to Quality and Value		
2A: Foundational payments for infrastructure & operations	None	0%
2B: Pay for reporting	None	0%
2C: Pay for performance	None	0%

Category 3: APMs Built on FFS Architecture		
3A: APMs with shared savings	None	0%
3B: APMs with shared savings and downside risk	Yes	100%
3N: Risk based payments NOT linked to quality	None	0%
Category 4: Population-Based Payment		
4A: Condition-specific population-based payment	None	0%
4B: Comprehensive population-based payment	None	0%
4B with reconciliation to FFS and ultimate accountability for TCOC	**Medicare AIPBP (Per CMMI and LAN)**: *CMMI actually includes VT All payer in the Annual LAN APM measurement effort and currently categorizes VT All payer as Category 4B (See definition from the LAN's APM Framework):* *"Payments in Category 4B are prospective and population-based, and they cover all an individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct."*	0%
4B with NO reconciliation to FFS	**Medicaid**	0%
4C: Integrated finance & delivery system	None	0%
4N: Capitated payments NOT linked to quality	None	0%

Services Included in Financial Targets (Total Cost of Care)
Services Included in Financial Targets: *Complete **Appendix A, Services Included in Financial Targets**, for all ACO-payer contracts. (Services must be comparable to All-Payer Financial Target Services as defined in section 1.f of the All-Payer ACO Model Agreement, to qualify as Scale Target ACO Initiative) **

Contract Reference(s): : https://www.ecfr.gov/current/title-42/part-425/subpart-G
Quality Measurement
Is financial arrangement tied to quality of care or the health of aligned beneficiaries? * **Yes**
Describe methodology for linking payments to quality of care or health of aligned beneficiaries (e.g., withhold, gate and ladder, etc.): Please see answer to Section 3, question 4.
Quality Measures: *Complete **Appendix B, Quality Measures**, for all ACO-payer contracts.*
Contract Reference(s): https://www.ecfr.gov/current/title-42/section-425.512
Attribution Methodology
Describe attribution methodology: The ACO is assigned beneficiaries through the "Preliminary Prospective Assignment with Retrospective Reconciliation" method. Under this method, CMS prospectively assigns beneficiaries to the ACO near the beginning of the performance period based on the most recently available claims data as well as any beneficiaries that have voluntarily aligned to an ACO professional by September 30th of the year prior to the current performance year. Quarterly during the performance year, CMS will generate another preliminary prospective assignment list for the ACO, based on a rolling 12-month assignment window. CMS will create a final assignment, for both benchmark years and the performance year, which is the retrospective reconciliation, after the performance year. The assignment criteria is the beneficiary must be enrolled in both Medicare Parts A and B, not part of Medicare Advantage or other group health plan for any months in the year, not assigned to any other shared savings initiative or CMS Model, live in the U.S. or U.S. territories, have at least one primary care service or FQHC claim with the ACO professional, and the beneficiary must receive the "plurality" of primary care services from providers within the ACO or choose a primary clinician participating in the ACO through Medicare.gov (or es.Medicare.gov).
Contract Reference(s): https://www.ecfr.gov/current/title-42/part-425/subpart-E
Patient Protections
Describe patient protections included in ACO contracts or internal policies: Patient protections are outlined in the Program Requirements and Beneficiary Protections regulations the ACO and its ACO participants are bound by. This includes, but is not limited to, compliance functions, data submission and certifications, beneficiary incentives, ACO screenings, prohibition on required referrals and cost shifting, public reporting and transparency, marketing limitations and requirements, beneficiary notifications, data opt-out and exclusion, audits and record retention, and additional CMS monitoring for compliance, including through 1-800-MEDICARE complaints.
Contract and Policy Reference(s): https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-425/subpart-D

Table 2: Services Included in Financial Targets

Indicate with "x" if category is included in the ACO's Medicare Program:

Category of Service or Expenditure Reporting Category	**Included in Financial Targets? *(X or blank)***
Hospital Inpatient	
Mental Health/Substance Abuse - Inpatient	x
Maternity-Related and Newborns	x
Surgical	x
Medical	x
Hospital Outpatient	

Hospital Mental Health / Substance Abuse	x
Observation Room	x
Emergency Room	x
Outpatient Surgery	x
Outpatient Radiology	x
Outpatient Lab	x
Outpatient Physical Therapy	x
Outpatient Other Therapy	x
Other Outpatient Hospital	x
Professional	
Physician Services	
Physician Inpatient Setting	x
Physician Outpatient Setting	x
Physician Office Setting	x
Professional Non-physician	x
Professional Mental Health Provider	x
Post-Acute Care	
DME	x
Dental	
Pharmacy	x (Part B)

Table 3: Quality Measures

Indicate with "x" if category is included in the ACO's Medicare Program:

The measures for 2025 are unknown at this time as CMS will be announcing the 2025 MSSP quality measures in the first week of November 2025.

Quality Measure	**Included in Quality Measures? *(X or blank)***
Screening for clinical depression and follow-up plan	
Tobacco use assessment and cessation intervention	
Hypertension: Controlling high blood pressure (ACO composite)	
Diabetes Mellitus: HbA1c poor control (ACO composite)	
All-Cause unplanned admissions for patients with multiple chronic conditions (ACO composite)	
Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys*	
% of Medicaid adolescents with well-care visits	
30-day follow-up after discharge from emergency department for mental health	
30-day follow-up after discharge from emergency department for alcohol or other drug dependence	
Initiation of alcohol and other drug dependence treatment	
Engagement of alcohol and other drug dependence treatment	
Risk-standardized, all-condition readmission	
Skilled nursing facility 30-day all-cause readmission	
Influenza immunization	
Pneumonia vaccination status for older adults	
Colorectal cancer screening	
Number of asthma-related ED visits, stratified by age	

HEDIS: All-Cause Readmissions	
Developmental screening in the first 3 years of life	
Follow-up after hospitalization for mental illness (7-Day Rate)	
Falls: Screening for future fall risk	
Body mass index screening and follow-up	
All-cause unplanned admissions for patients with Diabetes	
All-cause unplanned admissions for patients with Heart Failure	
Breast cancer screening	
Statin therapy for prevention and treatment of Cardiovascular Disease	
Depression remission at 12 months	
Diabetes: Eye exam	
Ischemic Vascular Disease: Use of aspirin or another antithrombotic	
Acute ambulatory care-sensitive condition composite	
Medication reconciliation post-discharge	
Use of imaging studies for low back pain	
Add Additional Measures as Needed	