STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY23 ACCOUNTABLE CARE ORGANIZATION BUDGET ORDER

In re: Lore Health ACO LLC)
Fiscal Year 2023)
) Docket No. 21-002-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). Fiscal Year 2023 (FY23) is the sixth year that ACO budgets are subject to Board review. Below, we describe the relevant legal framework, outline the criteria that the Board considered during its review, and present specific Findings and Conclusions in support of our Order approving an FY23 budget for Lore Health ACO LLC (Lore).

LEGAL FRAMEWORK

Under the ACO oversight statute, the Board's review of ACO budgets differs depending on whether an ACO has more or less than 10,000 attributed lives in Vermont. 18 V.S.A. § 9382(b)(1)-(2). For ACOs with fewer than 10,000 attributed lives, the Board may consider the factors set out in 18 V.S.A. § 9382(b)(1) "as the Board deems appropriate to a specific ACO's size and scope." 18 V.S.A. § 9382(b)(2). The statutory factors that the Board may – but is not required to – consider in reviewing the budget of an ACO with fewer than 10,000 lives generally fall into the following categories:

- Historic and future expenditures and the effects of care models on utilization, including the provision of innovative services;
- The ACO's efforts to strengthen and provide resources to primary care, address social determinants of health and the impacts of childhood trauma, integrate community providers, improve care coordination, and reduce duplication of services in partnership with the Blueprint for Health;
- Health resource allocation priorities;
- Transparency of the ACO's costs;
- Effects of Medicaid reimbursement on other payers;
- Solvency and ability to assume financial risk;
- Administrative costs;
- The character, competence, fiscal responsibility and soundness of the ACO and its leaders; and
- The Office of the Health Care Advocate's (HCA) feedback and public comment.

See 18 V.S.A. § 9382(b)(1). The Board must therefore consider the size and scope of an ACO with less than 10,000 lives when reviewing its budget. Based on its consideration of the size and scope of Lore's operations in Vermont, the Board's review 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.

The Board's budget review must also consider any benchmarks established by Rule by the Board and 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 CMS. *See* GMCB Rule 5.000, § 5.405(c).

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).

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).

FY23 REVIEW PROCESS

The review process for Lore's FY23 budget is reflected in the following timeline:

06.22.22: The Board issued FY23 Medicare Only Non-Certified ACO budget guidance and reporting requirements.
09.30.22: Lore submitted its proposed FY23 budget to the Board.
10.24.22: Lore presented its budget at a hearing before the GMCB.
10.28.22: Lore responded to questions from Board staff and HCA regarding Lore's proposed FY23 budget.
11.02.22: Board staff presented their analysis and preliminary recommendations regarding Lore's proposed FY23 budget.
11.10.22: Lore responded to questions from Board staff regarding Lore's corporate structure.
11.16.22: Board staff presented additional analysis and updated recommendations regarding Lore's proposed FY23 budget, and Board voted to approve Lore's FY23 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 from Onion River Community Access (ORCA) Media.[2]

FINDINGS

Overview

1. Lore Health ACO LLC ("Lore") is a Delaware limited liability company. Lore was previously named Gather Health ACO LLC, and changed its name in November of 2022. *See* Lore Budget Submission, 2; GMCB PowerPoint, 6 (November 16, 2022) (Staff Analysis II).

2. Lore is participating in the Medicare Shared Savings Program (MSSP), which is run by the Centers for Medicare and Medicaid Services (CMS). *See* Lore Budget Submission, 4. Within MSSP, Lore participates in the ENHANCED risk track. *See* Lore Budget Presentation, 9 (October 20, 2022).

3. Lore anticipates approximately 4,942 aligned Medicare beneficiaries for FY23 in Vermont, with one federally qualified health center (including 58 providers) as Lore's provider network in the state. *See* Lore Budget Submission, App. A-1. The federally qualified health center is Springfield Medical Care Systems Inc., with locations around Springfield Vermont. See GMCB PowerPoint, 17 (November 2, 2022) (Staff Analysis I).

4. Lore operates in five other states in addition to its presence in Vermont. *See* Lore Budget Presentation, 9.

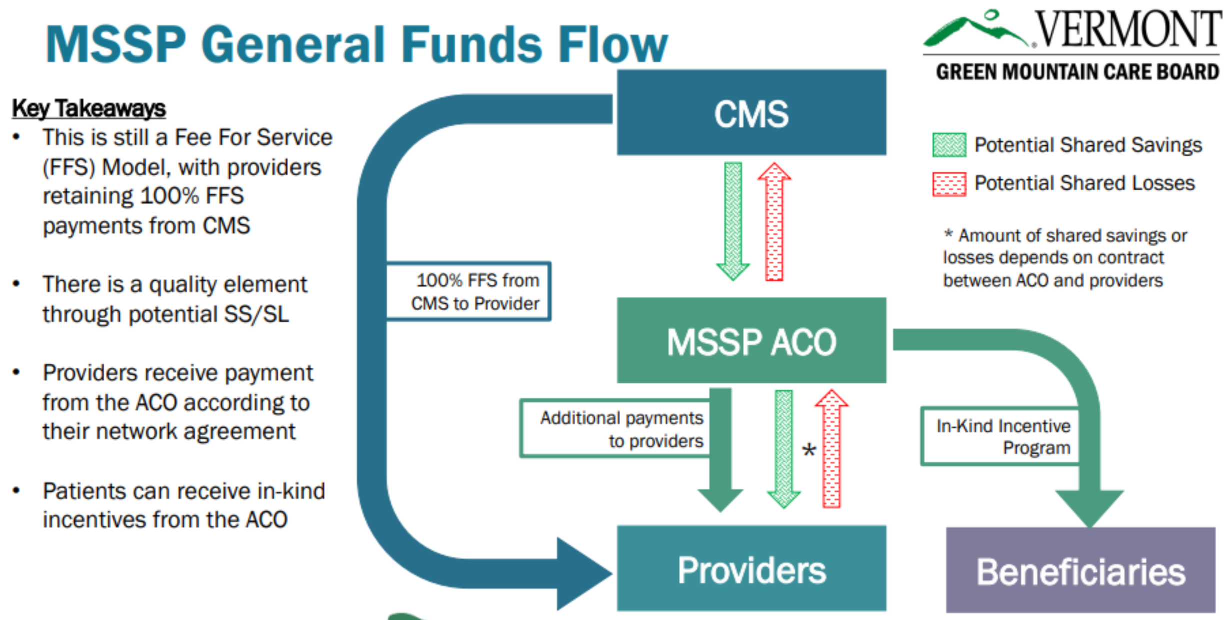
5. Lore's leadership presented to the GMCB at a public meeting on October 24, 2022 regarding Lore's business model and operations in Vermont. *See* Lore Budget Presentation (October 24, 2022), 1.

[1] Written budget materials are available at https://gmcboard.vermont.gov/FY23LoreHealth. Board presentations are available at https://gmcboard.vermont.gov/board/meeting-information/2022-meetings.
[2] https://www.orcamedia.net/series/green-mountain-care-board.

Payer Program and Risk Model

6. Medicare is the only payer that Lore participates with. *See* Lore Budget Submission, App. B. Risk and payment options are for all of Lore's aligned beneficiaries (both in and outside of Vermont), and the specific requirements for attribution, which can be claims-based or voluntary, as well as the other parameters for participation in the model are set by CMS as rules and regulations governing MSSP and in Lore Participation Agreement with CMS.

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, 20. There is potential for shared savings or shared loss, which would be paid between CMS and Lore. *See id.* Lore pays providers according to the terms of the network agreements between Lore and the providers. *See id.* Lore may also provide in-kind incentives directly to beneficiaries. The flow of payments for the MSSP model (as a general MSSP ACO, not Lore specifically) is outlined below:



Staff Analysis I, 20.

8. Risk corridors are established by CMS as part of MSSP under either a BASIC track or an ENHANCED track. *See* Lore Budget Presentation, 8. Lore has the potential to earn shared savings of up to 20% of the total benchmark or to be liable for shared losses between 8%-15% of the total benchmark, based on quality scores, under its Participation Agreement. *See* Lore Budget Submission, App. B.

9. Lore elected to participate in the ENHANCED track in MSSP, which has the highlighted risk corridors set out below:

Characteristic	BASIC Track's Glide Path				ENHANCED Track (risk/reward)
	Level A & Level B (one-sided model)	Level C (risk/reward)	Level D (risk/reward)	Level E (risk/reward)	
Shared Savings (once Minimum Savings Rate (MSR) met or exceeded)[1]	1st dollar savings at a rate of 40% if quality performance standard is met; not to exceed 10% of updated benchmark	1st dollar savings at a rate of 50% if quality performance standard is met, not to exceed 10% of updated benchmark	1st dollar savings at a rate of 50% if quality performance standard is met, not to exceed 10% of updated benchmark	1st dollar savings at a rate of 50% if quality performance standard is met, not to exceed 10% of updated benchmark	1st dollar savings at a rate of 75% if quality performance standard is met, not to exceed 20% of updated benchmark
Shared Losses (once Minimum Loss Rate (MLR) met or exceeded)	N/A	1st dollar losses at a rate of 30%, not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed 4% of ACO participant revenue capped at 2% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed 8% of ACO participant revenue in 2019-2024, capped at 4% of updated benchmark. The loss recoupment limit is the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program (QPP)[2] capped at 1 percentage point higher than the benchmark-based nominal risk amount[3]	1st dollar losses at a rate based on quality performance, with minimum shared loss rate of 40% and maximum of 75%, not to exceed 15% of updated benchmark

Lore Budget Presentation, 8.

10. Lore, as the ACO, assumes all the downside risk, with no downside risk passed on to providers. *See* Lore Budget Submission, 3, App. B.

11. The total cost of care benchmark is set by CMS for entities participating in MSSP using trended, risk-adjusted historic spending. *See* Lore Budget Submission, 4. The total cost of care benchmark is set prospectively and covers all Medicare Part A and Part B expenditures. *See id*. The preliminary benchmark is $9,900 per beneficiary. See Lore Budget Presentation, 11.

<u>*Financials (Revenues and Expenses)*</u>

12. As FY23 is Lore's first year of operation, it does not have past results or financials. *See* Lore Budget Submission, 5. Lore's projected financials for its Vermont operations are set out below:

Green Mountain Care Board - Gather Health ACO LLC

Expenditures and Performance

Traditional Medicare FFS Beneficiaries			5,000
Projected Annual Beneficiary Utilization and Expenditures			$ 9,900
Projected Vermont Provider/Supplier Medicare Billing (Benchmark)			$ 49,500,000
Performance Sensitivity Analysis (Projection)	3%	5%	7%
	$1,485,000	$2,475,000	$ 3,465,000
Medicare Payments to Vermont Providers (@5% Shared Savings)			$ 47,025,000
Net Shared Savings (@5%)			$ 2,475,000
Projected Vermont Beneficiary in-kind Incentives and Shared Savings with Vermont Providers			$ 1,495,000
Estimated ACO Care Management for Vermont Medicare Beneficiaries			$ 500,000
Estimated ACO Operations Expense			$ 225,000
Estimated Net Shared Savings (Retained by ACO)			$ 255,000
Projected Medicare Funds to Vermont Beneficiaries and Providers			99.0%
Estimated ACO Operating Expenses Percent			0.5%
Estimated Shared Savings Retained by ACO			0.5%

Lore Budget Submission, 11.

13. There are no anticipated payments from Vermont providers or Vermont aligned beneficiaries to Lore. *See* Lore Budget Submission, 6.

Model of Care

14. Lore states that its model of care is focused on addressing chronic diseases (such as diabetes, hypertension, dyslipidemia, chronic kidney disease) through lifestyle medicine interventions, appropriate utilization of care, and improved care coordination. *See* Lore Budget Submission, 8-9. Lore also states that its care model is on transitions of care and using available data sources, such as Admission Discharge Transfer data, and supporting beneficiaries' health needs through in-kind incentives that help beneficiaries manage and prevent chronic conditions and building community through the Gather Health Platform. *See* id; *see also* Lore Responses to GMCB Follow-up Questions (October 28, 2022), 3-4.

15. Lore stated that patients interact with the Lore platform by enrolling, then engaging in curated interactions between them and others on the platform. *See* Lore Responses to GMCB Follow-up Questions, 3-4; *see also* Staff Analysis I, 27. Lore stated that its platform also serves as the main way to participate in the ACO's chronic disease care management program. *See id*. Lore stated that beneficiaries will work with Lore or their provider if they do not have, or cannot navigate, digital access. *See id*. Lore described the community as intentionally designed to focus on preventing and reversing chronic diseases by building disease-specific, evidence-based community 'modules' for beneficiaries to interact with and meet. *See id*.

Data Collection and Use

16. Lore states that it will not sell or share any beneficiary data that it collects. *See* Lore Budget Submission, Hearing Transcript, Testimony of Dr. Mark Briesacher, 53:10-54:17 (October 20, 2022). Lore stated it would not monetize beneficiary data that it collects, but instead would use the data "to learn about how these interventions are going to make a difference in people's lives. But that learning will be applying to how do we just make the community better. How do we make care better." *Id.*

Integration with Vermont All-Payer Model Initiative

17. Providers that participate in MSSP cannot participate in other Medicare ACO initiatives, which means those participants could not participate in Vermont's Medicare ACO Initiative. *See* Staff Analysis, 30.

Public Comments

18. The Board did not receive any written public comments regarding Lore's FY23 budget. *See* Staff Analysis II, 7.

CONCLUSIONS

Under the ACO oversight statute, 18 V.S.A. § 9382, the GMCB's regulatory role for an ACO, like Lore, that only participates with Medicare payments is not to approve or deny the ACO's operation in Vermont. The GMCB's role, instead, is to approve or modify a proposed budget for the ACO for each year that the ACO elects to operate in Vermont. Lore bears the burden of justifying its proposed FY23 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 a specific ACO's size and scope. In light of Lore's limited size in Vermont, with only approximately 5,000 aligned beneficiaries, the fact that Lore is a new entrant in Vermont for FY23, and the programmatic elements of much of Lore's ACO model being established by CMS, the Board focused its review on the factors set out in the Legal Framework. *See* Findings, ¶¶ 3, 8, 9.

Medicare beneficiaries that are aligned to Lore remain enrolled in traditional Medicare, and they are not restricted from the traditional Medicare network that they would have access to if they were not aligned to Lore. *See* Findings, ¶ 7. The terms and conditions of the payer program arrangement are set by CMS, and the GMCB is not tasked with approving or modifying those terms. *See* Findings, ¶ 8, 9.

Lore is a new entrant in Vermont, so we conclude that it is appropriate to focus on collecting information about Lore's quality and financial performance for FY23 to help establish a baseline of performance for Lore's operations in Vermont. 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, using a

template that GMCB staff design for that purpose. We also require that Lore provide a description of how its model of care is working in Vermont, which Lore is required to submit on October 1, 2023.

Lore's model of care relies on the creation of a platform that beneficiaries will join and interact through. *See* Findings ¶¶ 14, 15. We are sensitive to the risk of misuse of any beneficiary data. Lore testified that it would not monetize beneficiary data by selling or sharing it for the benefit of a third party. *See* Findings, ¶ 16. To ensure this remains the case, we include a condition that Lore must notify the GMCB if its use of beneficiary data changes, and a certification along with Lore's FY24 budget submission attesting to its continued commitment not to sell any beneficiary data.

ORDER

Based on our Findings and Conclusions above, and pursuant to 18 V.S.A. § 9382, we hereby approve Lore's FY23 budget as submitted and subject to the conditions set forth below:

1. Lore shall provide to GMCB Lore's FY23 shared savings/losses, segmented for Vermont.

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

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

4. Lore shall provide a copy of the terms and conditions given to beneficiaries upon signing up for the Lore Health Platform, as well as any other marketing or informational materials shared with beneficiaries.

    a. Lore shall notify the GMCB immediately if the intended use of beneficiary data changes from what Lore presented to the GMBC in connection with the review of Lore's FY23 budget, as summarized in Findings, ¶ 16. If no changes are reported to GMCB, Lore shall provide a certification under oath with the submission of its FY24 budget that no changes have been made to Lore's intended use of beneficiary data.

5. Lore shall provide a bi-annual update about how Lore's care model is working in Vermont, including the number of Vermont attributed patients registered to the Lore Health Platform and any unique Vermont challenges. Lore's first report shall be submitted with its FY24 budget submission on October 1, 2023. The development of the report template is delegated to GMCB staff.

GENERAL

6. 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: May 22, 2023 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: May 22, 2023

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

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