VERMONT
GREEN MOUNTAIN CARE BOARD

ACO Oversight
FY 2024 Medicare Only ACO Budget Review
Lore Health ACO and Vytalize Health 9 ACO

Staff Analysis and Recommendations

November 20, 2023

Agenda

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1. GMCB Authority and Criteria
2. Background and Overview
3. FY24 Lore Health Budget Review & Staff Recommendations
4. Board Questions/Discussion
5. Public Comment
6. FY24 Vytalize Health Budget Review and Staff Recommendations
7. Board Questions/Discussion
8. Public Comment
9. Next Steps

ACO Oversight Statute/Rule

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- What is the Board approving?
  - Certification is not required under 18 V.S.A. § 9382(a)
  - Under 18 V.S.A. § 9382(b)(2) and Rule 5.405, GMCB shall **review and approve or modify** an ACO's budget.
    - Guidance approved by the Board earlier this year for Medicare-only ACOs with fewer than 10,000 attributed lives
  - Scope of Board's jurisdiction
- Reporting obligations under Rule 5.501

Timeline and Public Comment

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Timeline

November 1, 2023	Lore Health Budget Hearing
November 15, 2023	Vytalize Health 9's Budget Hearing
November 20, 2023	GMCB Staff Presentation
December 6, 2023	Deliberations and Potential Vote

Public Comment via GMCB Website

- Submit by Friday, December 1, 2023, to be considered ahead of the GMCB vote.
- One written public comment was received as of 11/17/2023.

Public Comment

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Office of the Health Care Advocate

Concerns:

- Lack of evidence regarding efficacy of model of care
- Lack of transparency
- Profit-priority motive

Recommendations:

- Lore to submit financial and quality reporting to GMCB annually
- Establish deadline for confidentiality requests in budget guidance
- GMCB should expand the scope of authority over Medicare-Only ACOs

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LORE HEALTH ACO

FY24 Budget

High-Level Overview

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- **What:** The Medicare Shared Savings Program (MSSP), which has been in operation since 2012.
  - 456 ACOs are currently participating in the model, covering 10.9 million beneficiaries
- **Who:** Agreement between CMS, ACO, and providers who contract with the ACO.
- **ACO:** Lore Health
  - 5-Year Participation Agreement in the Enhanced Track
  - 2024 will be Lore Health's second year
  - Providers in 5 states (down from 6 in 2023), including Vermont

How does the MSSP Model impact Medicare beneficiaries' costs and care?

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- Beneficiaries aligned to ACOs are still in Traditional Medicare:
  - Access to the entire Traditional Medicare network
  - Alignment to the ACO does not affect out-of-pocket costs and premiums
  - Does not affect use of supplemental insurance (Medigap)
- ACO Attributed Beneficiary Rights:
  - Beneficiary Notifications with option to decline claims data sharing
- Beneficiaries may have access to additional in-kind benefits

Program Safeguards

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- Screening of ACO Applicants (42 CRF § 425.305a)
  - All applicants are reviewed during the application processes and periodically thereafter with regard to their program integrity history, including any history of Medicare program exclusions or other sanctions and affiliations with individuals or entities that have a history of program integrity issues.
- Prohibition on Certain Referrals and Cost Shifting(42 CRF § 425.305b)
  - ACO providers may not require that beneficiaries be referred only within the ACO's network.

Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-425/subpart-D

Public Reporting and Transparency

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- Compliance Plan (42 CRF § 425.300)
  - ACOs must have a compliance plan with specific elements specified by CMS.
- Public Reporting and Transparency (42 CRF § 425.308)
  - Public webpage with information on the ACO's name and contact information, the ACO's governing body, shared savings/losses, performance on quality measures.
- Beneficiary Notifications (42 CFR § 425.312)
  - Including the beneficiary's opportunity to decline claims data sharing (42 CFR § 425.708)
- Audits and Record Retention (42 CRF § 425.314)
  - CMS, DHHS, the Comptroller General, the Federal Government or their designees have the right to audit, inspect, investigate, and evaluate any books, contracts, records, documents and other evidence of the ACO, ACO participants, and ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities

Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-425/subpart-D

CMS Monitoring of ACOs
(42 CRF § 425.316)

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- ACO avoidance of at-risk beneficiaries
- ACO compliance with quality performance standards
- ACO financial performance
- ACO eligibility for advance investment payments

Source: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-425/subpart-D

Key Areas Of Review – Guidance

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Sec. 1: ACO Information

Sec. 2: Provider Network

Sec. 3: Payer Program

Sec. 4: Budget and Finances

Sec. 5: Care Model

Sec. 6: VT All-Payer Model Alignment

Section 1: ACO Information

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- **Governing Body:**
  - CMS sets the ACO's governing body requirements (42 CFR § 425.106)
  - Governing body information on Lore Health's website
    - Governing body includes two clinicians from the participating provider in Vermont (of 12 total Governing Body members)
- **Recommendation:** None

Section 2: Provider Network

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- Lore Health has providers in 5 states.
- There is no plan to expand the provider network within Vermont at this time, though the ACO is open to Vermont providers who are aligned with Lore's model of care.

Section 2: Provider Network

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HSA	Facility Name	Category	Org. Type	Provider Count	Attributed Lives
Springfield	Springfield Medical Care Systems Inc.	PCP and Specialty	FQHC	58	3,786

- Locations in both Vermont and New Hampshire; number of attributed lives may include residents of both states.
- No network changes between 2023-2024
- Provider contract reported to GMCB and CMS monitoring (42 CFR 425.204(c)(6))

Recommendation: None

Section 3: Payer Program

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- Medicare Only Program
  - Risk model is set by the MSSP Participation Agreement with CMS, based on which track the ACO choses
- Attribution
  - Preliminary prospective assignment with retrospective reconciliation
  - Voluntary alignment

MSSP General Funds Flow

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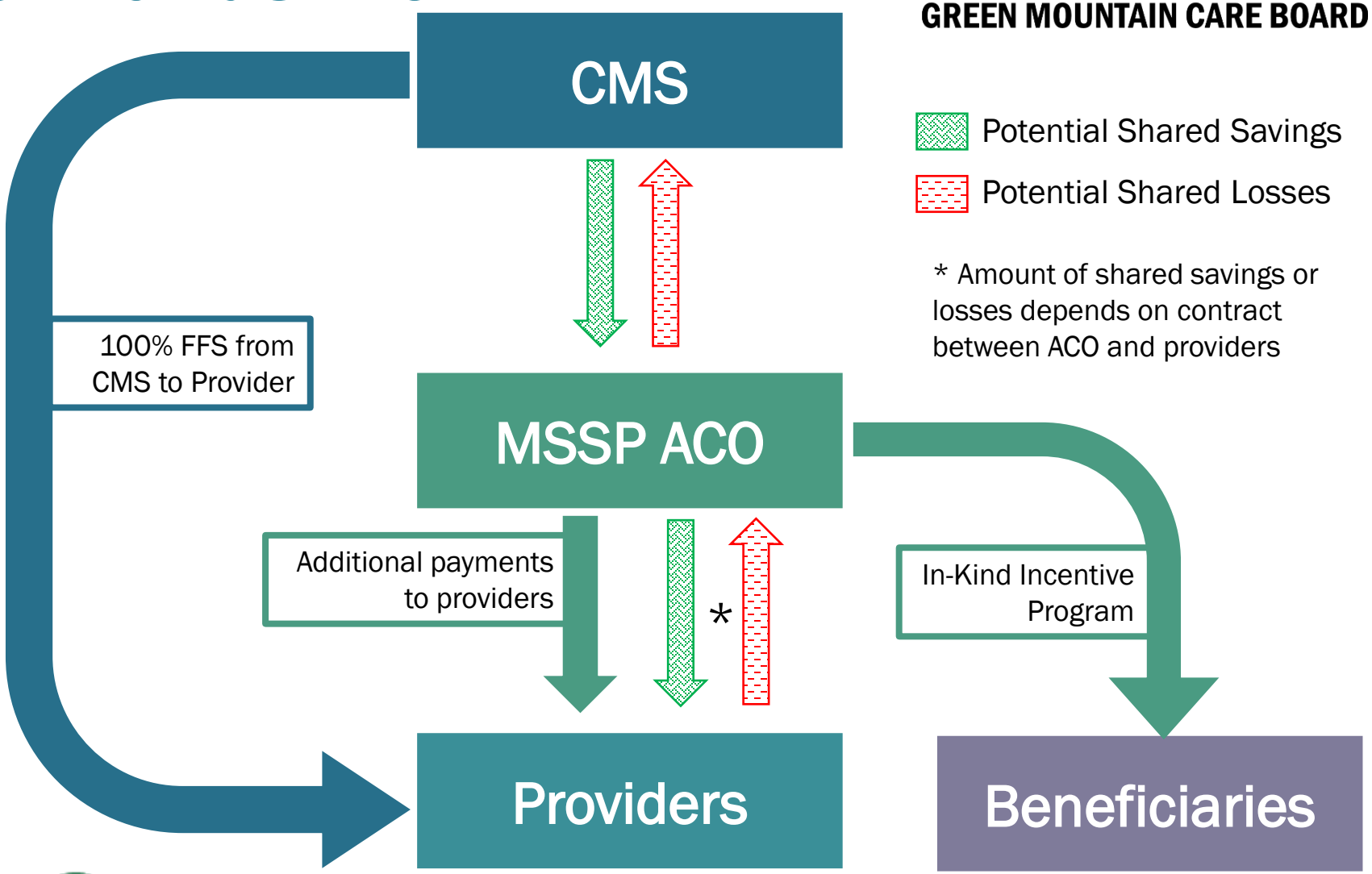
Key Takeaways

- This is still a Fee For Service (FFS) Model, with providers retaining 100% FFS payments from CMS
- There is a quality element through potential SS/SL
- Providers receive payment from the ACO according to their network agreement
- Patients can receive in-kind incentives from the ACO



Section 3: Risk Model

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- Under the MSSP Agreement, CMS provides standard risk model options.
- Lore Health chose the Enhanced Track- highest risk track
- Shared Savings/Losses:
  - Shared Savings – 1st dollar savings at a rate of 75% if quality performance standard is met, not to exceed 20% of updated benchmark. Must meet quality performance standards.
  - Shared Losses – 1st dollar losses at a rate based on quality performance, with shared loss rate of 40% to 75%, not to exceed 15% of updated benchmark.
- Risk Mitigation
  - Minimum Savings/Loss Ratio: Lore Health selected 0.5% (options of 0–2%)
  - CMS requires ACOs to have a repayment mechanism / financial guarantee (set by CMS)
  - CMS truncates claims at 99th percentile

See: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ssp-aco-participation-options.pdf

Section 3: Payer Program

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- **Key Points:**
  - Risk model is standardized under the agreement with CMS.

- **Recommendation 1:** Continuation of FY23 Budget Order Condition 1: Lore Health provides to GMCB its shared savings/losses, segmented for Vermont. FY24 data will not be available until summer 2025.

Section 4: Budget and Finances

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Lore Health- Vermont Only	Budget Projection
Traditional Medicare Beneficiaries	3,800
Annual Beneficiary Utilization and Expenditures	$9,941
VT Provider/Supplier Medicare Benchmark	$36.5M
VT Shared Savings/Shared Losses	<u>If Shared Savings:</u> Shared Savings % x Medicare Benchmark x Quality Performance Score x CMS Share
	<u>If Shared Losses:</u> Shared Losses % x Medicare Benchmark x Quality Performance Score x CMS Share

Section 4: Budget and Finances

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- **Key Points:**
  - Final financial results for FY23 will be available in late 2024.

- **Recommendation 2:** Continuation of FY23 Budget Order Condition 2: Lore Health provides an updated version of their Vermont financial summary with actuals. GMCB staff to develop template and set deadline.

Section 5: Model of Care

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Review Criteria:

- Strengthen primary care
- Support appropriate utilization
- Integrate with community-based providers and the Blueprint for Health
- Prevent duplication of services

18 V.S.A. § 9382 b(1):(A)(F)(G)(H)(P)

Section 5: Model of Care

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- Lore Health's Focus: Addressing chronic diseases through lifestyle medicine interventions
  - Emphasis on health equity, addressing social determinants of health, chronic disease self-management, connecting patients to resources, improving experience with health care system
  - In-kind incentives that help beneficiaries manage and prevent chronic conditions and aim to narrow health equity gaps
  - Pending CMS approval, looking to implement 3-Day SNF Rule waiver for 2024

Section 5: Model of Care

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- Singular population health initiative: Lore Health Community
  - Objective is to educate and enable patients to be their own agents of change for their lifestyle
  - Outcomes are judged by improvements in eCQM scores over time, improvements in utilization over time
- ACO participants have access to utilization data (Admission Discharge Transfer data)
- No specific care coordination initiatives or integration with community-based providers reported, but network practice is embedded with the Blueprint for Health model
- Shared savings may be invested in strengthening primary care

Section 5: Model of Care

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- In guidance, GMCB had explained that FY24 reporting of Vermont performance data would be required. It was asked that the ACO review the metrics listed in Appendix D and justify any proposed deletions or additions to the metrics.
  - Lore recommended aligning Vermont-specific reporting to CMS performance data for Medicare-Only ACOs.
  - Lore testified that they do not have people on staff to process the data received from CMS in order to provide the GMCB metrics; they can provide the data but would require additional time and money to do so.

Section 5: Model of Care

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Key Points:

- Lore Health is focused on the practice of lifestyle medicine to improve the health of Medicare beneficiaries
- Their model includes use of a beneficiary-facing mobile application/platform
- Able to report on metrics suggested by GMCB, however it would require investment on the part of the ACO

Section 5: Model of Care

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- **Recommendation 3:** Continuation of FY23 Budget Order Condition 3: Lore Health provides to GMCB its quality reporting, segmented for Vermont if possible, with appropriate restrictions to protect patient confidentiality.
- **Recommendation 4:** Following three years of activity in Vermont, Lore Health provides performance reporting on GMCB-specified metrics including the categories of inpatient medical, inpatient surgical, emergency department, professional office visits, ambulatory care sensitive admissions, and any additional metrics. Report template and metrics to be determined by GMCB staff by June 30, 2024.
- **Recommendation 5:** Continuation of FY23 Budget Order Condition 5: Lore Health provides a bi-annual update about how Lore Health's care model is working in Vermont. Report template to be developed by GMCB staff.
- **Recommendation 6:** Lore Health staff engage in an orientation led by Blueprint for Health by March 31, 2024.

Section 6: Vermont APM Agreement Scale Target ACO Initiative

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- **Scale:** No
- **HCP-LAN Category 3B**: Alternative payment model with shared savings and downside risk
- **Financial targets** are well aligned between APM and MSSP, with all target areas overlapping (note some are rare and pharmacy is limited to Part B)
- **Quality Targets:** Overlapping measures with current APM:
  - Screening for clinical depression and follow-up plan
  - Hypertension: Controlling high blood pressure
  - Diabetes Mellitus: HbA1c poor control
  - All-cause unplanned admissions for patients with multiple chronic conditions (new for 2024)
  - CAHPS patient experience surveys (new for 2024)

- **Recommendation:** None

Recommendations Summary

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- **Recommendation 1:** Lore Health provides to GMCB its shared savings/losses, segmented for Vermont.
- **Recommendation 2:** Lore Health provides an updated version of their Vermont financial summary with actuals, including breakout for in-kind incentive spending. GMCB staff to develop template and set deadline.
- **Recommendation 3:** Continuation of FY23 Budget Order Condition 3: Lore Health provides to GMCB its quality reporting, segmented for Vermont if possible, with appropriate restrictions to protect patient confidentiality.
- **Recommendation 4:** Following three years of activity in Vermont, Lore Health provides reporting on GMCB-specified metrics including the categories of inpatient medical, inpatient surgical, emergency department, professional office visits, ambulatory care sensitive admissions, and any additional metrics. Report template and metrics to be determined by GMCB staff by June 30, 2024.
- **Recommendation 5:** Continuation of FY23 Budget Order Condition 5: Lore Health provides a bi-annual update about how Lore Health's care model is working in Vermont. Report template to be developed by GMCB staff.
- **Recommendation 6:** Lore Health staff engage in an orientation led by Blueprint for Health by March 31, 2024.

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VYTALIZE HEALTH 9 ACO

FY24 Budget

High-Level Overview

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- **What:** The ACO REACH (Realizing Equity, Access, and Community Health) model, which has been in operation since 2023.
  - 132 ACOs are currently participating in the model, covering 2.1 million beneficiaries
- **Who:** Agreement between CMS, ACO, and providers who contract with the ACO.
- **ACO:** Vytalize Health 9
  - 3 Year Participation Agreement
  - 2024 will be Vytalize 9's first year in Vermont
  - Providers in 36 states including Vermont

ACO REACH

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- Advance Health Equity to Bring the Benefits of Accountable Care to Underserved Communities.
- Promote Provider Leadership and Governance
- Protect Beneficiaries and the Model with More Participant Vetting, Monitoring, and Transparency

REACH and Medicare Beneficiaries

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- Beneficiaries aligned to ACOs are still in Traditional Medicare:
  - Access to the entire Traditional Medicare network
  - Alignment to the ACO does not affect out-of-pocket costs and premiums
  - Does not affect use of supplemental insurance (Medigap)
- ACO Attributed Beneficiary Rights:
  - Beneficiary Notifications with option to decline claims data sharing
- Beneficiaries may have access to additional Benefit Enhancements

Program Safeguards

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- CMS monitors levels of care to determine if REACH ACOs are stinting on beneficiary care.
- CMS conducts compliance audits throughout the year, investigates beneficiary complaints, and conducts beneficiary experience of care surveys (CAHPS) annually to measure changes in beneficiary satisfaction
- CMS will monitor whether beneficiaries aligned to the model are being shifted into or out of Medicare Advantage.

See: https://www.cms.gov/priorities/innovation/media/document/aco-reach-mont-comp-ovw

Key Areas Of Review – Guidance

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Sec. 1: ACO Information

Sec. 2: Provider Network

Sec. 3: Payer Program

Sec. 4: Budget and Finances

Sec. 5: Care Model

Sec. 6: VT All-Payer Model Alignment

Section 1: ACO Information

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- **Governing Body:**
  - CMS sets the ACO's governing body requirements – 75% must be participant providers
  - Governing body information on Vytalize Health's website
- Vytalize Health LLC- parent company
  - Based in New Jersey
  - Venture capital-backed
  - Other ACOs as part of organization

Section 2: Provider Network: Little Rivers Health

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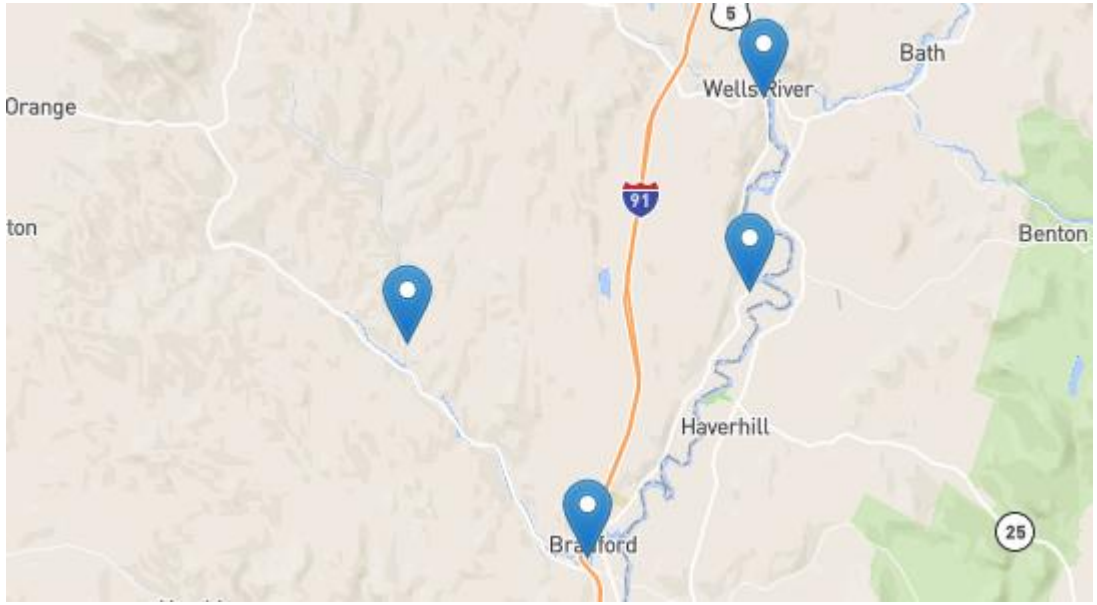

- FQHC
- 23 Providers
- 1342 Attributed Lives; some may be New Hampshire
- Bradford, Wells River, East Corinth, Newbury
  - Primary Care
  - Obstetrics
  - Behavioral Health
  - Dental

Section 2: Provider Network: Five-Town Health Alliance

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- Mountain Health Center
- FQHC
- 29 Providers
- 663 Attributed Lives
- Bristol
  - Primary Care
  - Behavioral Health
  - Dental

Section 2: Provider Network

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- Provider contract reported to GMCB and CMS monitoring
- No network expansion plans reported as of budget submission

Recommendation: None

Section 3: Payer Program

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- Medicare Only Program
  - Risk model is set by the ACO REACH agreement with CMS, based on which track the ACO choses
- Attribution
  - Preliminary prospective assignment with retrospective reconciliation
  - Voluntary alignment

REACH General Funds Flow

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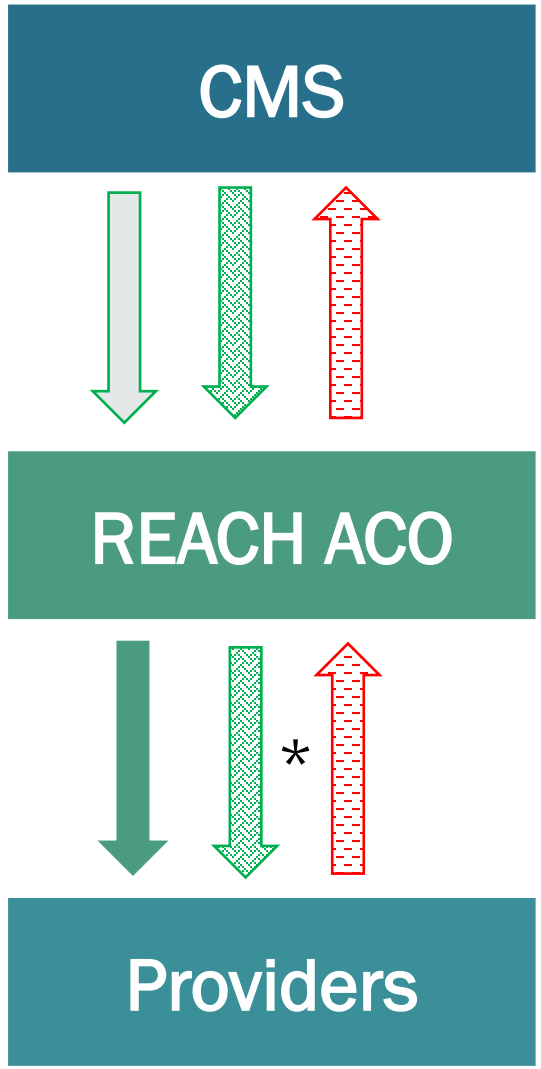
<u>Key Takeaways</u>

- Capitated Payment model
- There is a quality withhold through potential SS/SL
- Providers receive payment from the ACO according to their network agreement
- Benefit Enhancements available
- Note: All aligned beneficiaries retain full Original Medicare benefits and can see any Medicare physician



- Monthly Capitated Payments
- Potential Shared Savings
- Potential Shared Losses
- Payments to Providers

* Amount of shared savings or losses depends on contract between ACO and providers

Risk Model

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- Under the ACO REACH model, CMS provides standard risk model options.
- Vytalize chose the highest risk option – Global Risk
- Shared Savings/Losses:

% of benchmark	Savings/Losses Rate
Less than 25%	100%
25-35%	50%
35-50%	25%
More than 50%	10%

- Vytalize holds Surety Bonds and Aggregate Stop-Loss insurance to cover potential losses (financial guarantee is required by CMS)
- In this ACO, providers are not liable for downside risk

Health Equity

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- Under the ACO REACH model, ACOs are required to have an approved Health Equity Plan
- Vytalize's Health Equity Plan will be rolled out nationally for 2024
  - Addressing food insecurity
- Health Equity Data Reporting requirement (demographics and SDOH data)
- CMS will stratify all aligned beneficiaries using a composite measure that incorporates a combination of **Area Deprivation Index** and **Dual Medicaid Status.** Beneficiaries in the top decile on this measure will receive a $30 PBPM upward adjustment towards the ACO's benchmark, while beneficiaries in the bottom five deciles will receive a smaller $6 PBPM downward adjustment, allowing a roughly budget neutral impact.

Section 3: Payer Program

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- **Key Points:**
  - Risk model is standardized under the agreement with CMS
  - Health Equity is a key element of REACH model

- **Recommendation 1:** Vytalize 9 provides to GMCB its shared savings/losses, segmented for Vermont. FY24 data will not be available until summer 2025.

Section 4: Budget and Finances

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FY24 Budget Projections – Vermont Only	Amount	Notes
Projected Vermont Benchmark	$31M	Based on 2,005 beneficiaries $15,500 spending per beneficiary
Projected Shared Savings	$1.9M	6% estimate
Projected Vermont Provider portion of SS	$745,860	40% of estimated shared savings
Medicare Payments to Vermont Providers	$29.2M	Claims-based

Under the GPDC Model, Vytalize's comparable ACO performed in the top quartile of all DCEs for cost in 2022.

Section 4: Budget and Finances

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- Shared savings/losses are not determined or distributed until approximately 10 months after the close of the program year.
- Network providers are not liable if shared losses are experienced by the ACO. The ACO will reimburse CMS for these losses.
- Vytalize testified that their provider contracts allow the ACO under some circumstances to “claw back” advances of shared savings against payments in future years, but Vytalize also testified that they have not exercised that ability to date.

Section 4: Budget and Finances

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- **Key Points:**
  - Final financial results for FY24 will be available in late 2025.

- **Recommendation 2:** Vytalize provides an updated version of their Vermont financial summary with actuals. GMCB staff to develop template and set deadline.

Section 5: Model of Care

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Review Criteria:

- Strengthen primary care
- Support appropriate utilization
- Integrate with community-based providers and the Blueprint for Health
- Prevent duplication of services

18 V.S.A. § 9382 b(1):(A)(F)(G)(H)(P)

Section 5: Model of Care

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- Focus on supporting primary care practices in value-based care through incentivizing care coordination and implementation of population health initiatives.
- Population Health Initiatives:
  - Annual Wellness Visits
  - Post-Discharge Follow-Up (ED and inpatient)
  - Healthy Holidays
- Emphasis on evidence/literature review for ongoing organizational prioritization of population health goals and outcomes measurement
- Benefit Enhancements not currently implemented

Section 5: Model of Care

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- In guidance, GMCB had explained that FY24 reporting of Vermont performance data would be required. It was asked that the ACO review the metrics listed in Appendix D and justify any proposed deletions or additions to the metrics.
  - Vytalize testified that this data would be available approximately two weeks following receipt of CMS claims data.

Section 5: Model of Care

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- **Recommendation 3:** Vytalize Health 9 provides to GMCB its quality reporting, segmented for Vermont if possible, with appropriate restrictions to protect patient confidentiality.
- **Recommendation 4:** Following three years of activity in Vermont, Vytalize Health 9 provides performance reporting on GMCB-specified metrics including the categories of inpatient medical, inpatient surgical, emergency department, professional office visits, ambulatory care sensitive admissions, and any additional metrics. Report template and metrics to be determined by GMCB staff by June 30, 2024.
- **Recommendation 5:** Vytalize Health 9 provides a bi-annual update (first report submitted with FY25 budget submission on October 1, 2024) about how Vytalize Health 9's care model is working in Vermont. Report template to be developed by GMCB staff.
- **Recommendation 6:** Vytalize Health 9 staff engage in an orientation led by Blueprint for Health by March 31, 2024.

Section 6: Vermont APM Agreement Scale Target ACO Initiative

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- **Scale:** No
- **HCP-LAN Category 3B**: Alternative payment model with shared savings and downside risk
- **Financial targets** are well aligned between APM and REACH, with all target areas overlapping
- **Quality Targets:** Overlapping measures with current APM:
  - All-cause unplanned admissions for patients with multiple chronic conditions
  - CAHPS patient experience surveys
  - Risk-standardized all-condition readmission
  - All-cause unplanned admissions for patients with Diabetes
  - All-cause unplanned admissions for patients with Heart Failure
- **Recommendation:** None

Recommendations Summary

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- **Recommendation 1:** Vytalize Health 9 provides to GMCB its shared savings/losses, segmented for Vermont.*
- **Recommendation 2:** Vytalize Health 9 provides an updated version of their Vermont financial summary. GMCB staff to develop template and set deadline.
- **Recommendation 3:** Vytalize Health 9 provides to GMCB its quality reporting, segmented for Vermont if possible, with appropriate restrictions to protect patient confidentiality.
- **Recommendation 4:** Vytalize Health 9 provides a bi-annual update (first report submitted with FY25 budget submission on October 1, 2024) about how Vytalize Health 9's care model is working in Vermont. Report template to be developed by GMCB staff.
- **Recommendation 5:** Vytalize Health 9 staff engage in an orientation led by Blueprint for Health within the first quarter of 2024.

Next Steps

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Public Comment Period Reminder

- A potential vote on Vytalize's FY24 budget is scheduled for December 6, 2023. Please submit public comment via GMCB website by Friday, December 1, to be considered ahead of the vote.

Remaining Agenda for Today:

- Board Questions/Discussion
- HCA Comments
- Public Comment

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REFERENCE SLIDES

ACO Oversight Statute/Rule

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- What is the Board approving?
  - Certification is not required under 18 V.S.A. § 9382(a)
  - Under 18 V.S.A. § 9382(b)(2) and Rule 5.405, GMCB shall **review and approve or modify** an ACO's budget.
    - Guidance approved by the Board earlier this year for Medicare-only ACOs with fewer than 10,000 attributed lives
  - Scope of Board's jurisdiction
- Reporting obligations under Rule 5.501

Budget Review Process

18 V.S.A. § 9382(b)(2) and Rule 5.405(c)

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In deciding whether to approve or modify the proposed budget of an ACO projected to have fewer than 10,000 attributed lives in Vermont during the next Budget Year, the Board will take into consideration:

1. any benchmarks established under section 5.402 of this Rule;
2. those criteria listed in 18 V.S.A. § 9382(b)(1) ***that the Board deems appropriate to the ACO's size and scope***;
3. 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; and
4. any other issues at the discretion of the Board.

Board Review Scope

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- Staff recommend Board consider 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;

Board Review Scope (cont.)

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- Recommended factors from 18 V.S.A. § 9382(b)(1) continued:
  - 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.

Acronym List

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- ACO — Accountable Care Organization
- APM — All-Payer Model
- CMS — Centers for Medicare & Medicaid Services
- FFS — Fee-for-Service
- FY – Fiscal Year
- GPDC – Global and Professional Direct Contracting
- GMCB — Green Mountain Care Board
- HCP-LAN – Health Care Payment Learning & Action Network
- HCA — Health Care Advocate
- HSA — Health Service Area
- MSSP — Medicare Shared Savings Program
- PCP — Primary Care Provider
- PMPM — Per-Member Per-Month
- PY — Performance Year
- ACO REACH – Realizing Equity, Access, and Community Health ACO program
- SNF — Skilled Nursing Facility
- SS/SL — Shared Savings/Shared Losses
- TCOC — Total Cost of Care