VERMONT
GREEN MOUNTAIN CARE BOARD

ACO Oversight
FY 2023 Budget Review
Lore Health ACO LLC
(formerly Gather Health)

Staff Recommendations and Potential Vote

Agenda for Today

1. Review New Information
2. Summary of Recommendations
3. Board Questions/Discussion
4. Public Comment
5. Potential Vote

Scope of Medicare-Only Review

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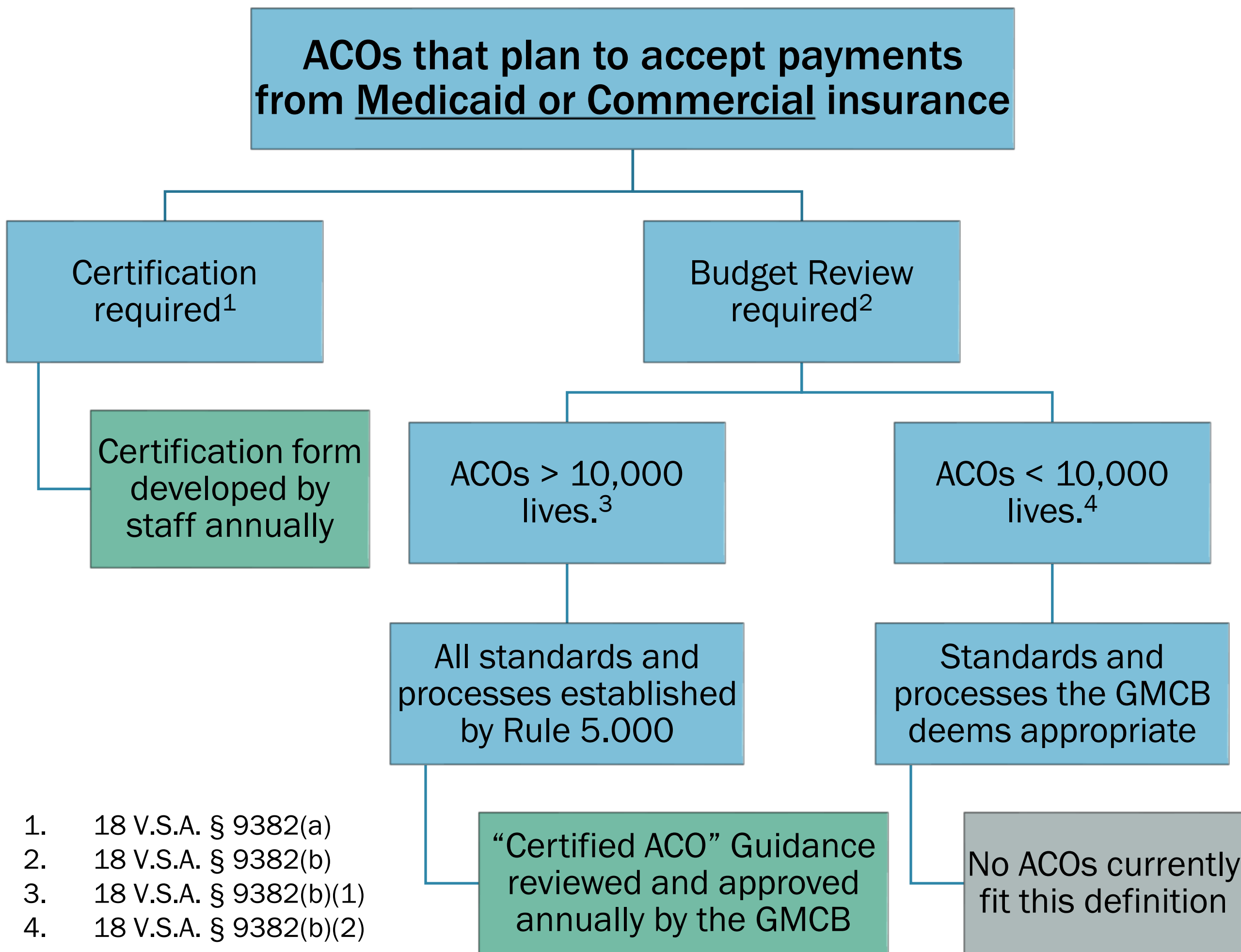

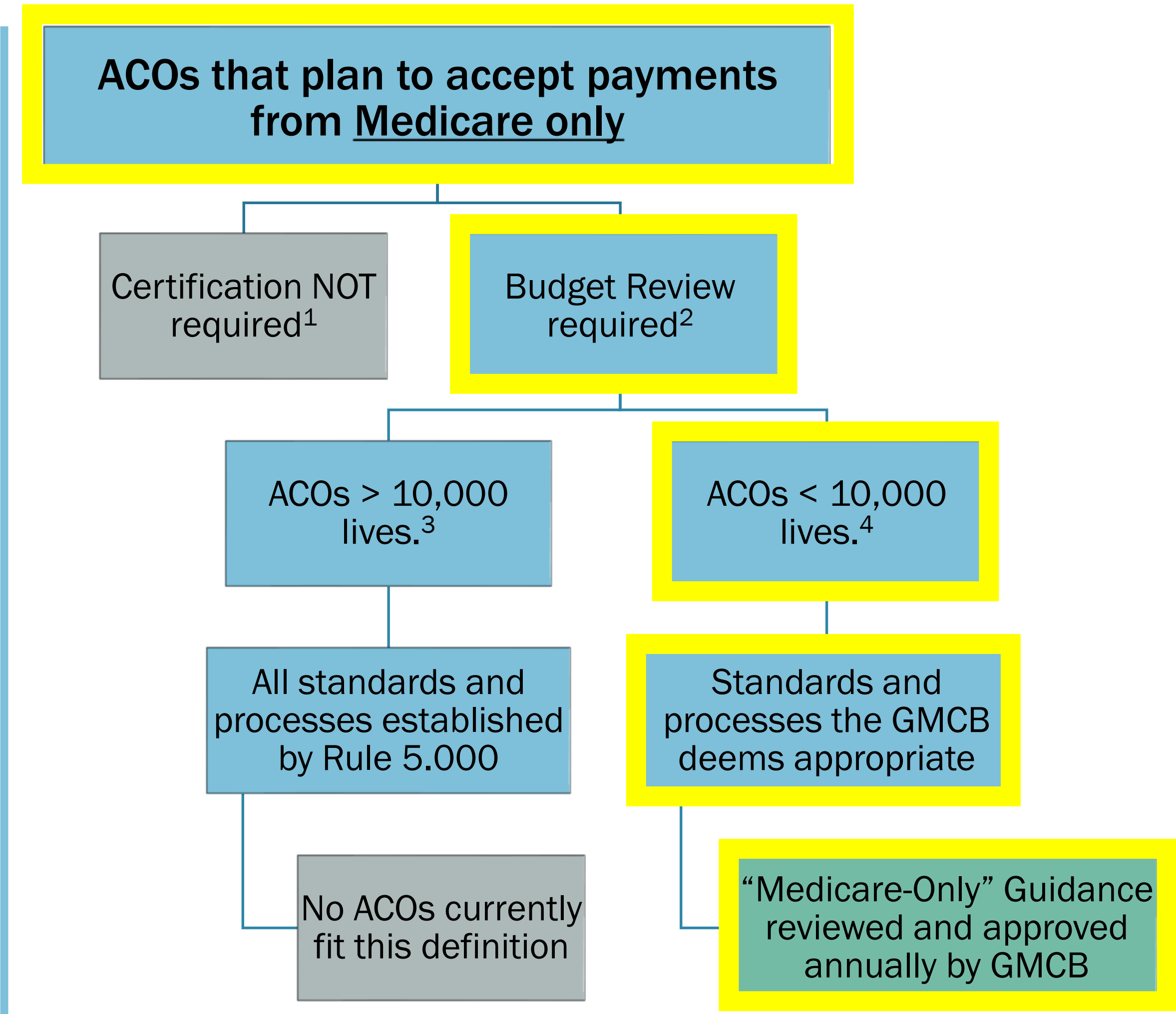

1. 18 V.S.A. § 9382(a)
2. 18 V.S.A. § 9382(b)
3. 18 V.S.A. § 9382(b)(1)
4. 18 V.S.A. § 9382(b)(2)

Scope for Medicare-Only Review

- Medicare-Only ACOs are not subject to certification
- Smaller ACOs are under a different section of the statute (Lore Health has less than 10,000 lives)
- Lore Health is participating in a standard Medicare model, with terms established under federal rule
- Lore Health is a multi-state ACO

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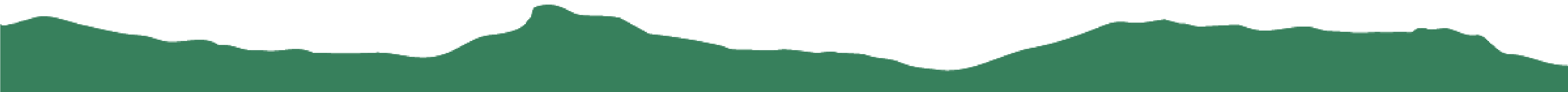
REVIEW OF NEW INFORMATION



Further Information from the ACO

Name Changed to Lore Health

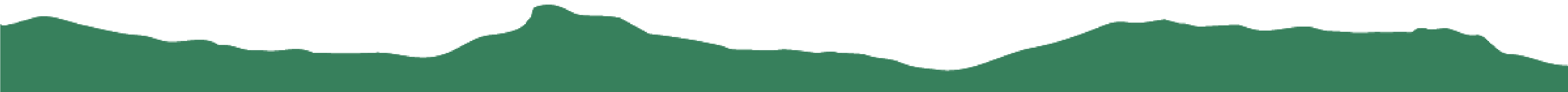
On November 3, 2022, the ACO informed the GMCB that: *The Gather Health ACO LLC legal entity submitted a legal name change due to another entity using and trademarking "Gather Health" shortly after our initial use. Our legal entity is now named "Lore Health ACO LLC".*

Corporate Structure and Data Use

GMCB received information from Lore Health providing further detail about their corporate structure and confirmation of what Lore Health said during the hearing that they will not sell or share beneficiary data.

Public Comment

No written public comment has been received for Lore Health's FY23 Budget (formerly Gather Health)



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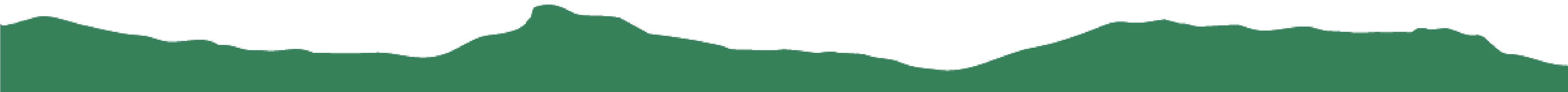
UPDATED STAFF RECOMMENDATIONS



Recommendation 1

- **Recommendation 1:** Lore Health provides to GMCB its shared savings/losses, segmented for Vermont.

- **Key Points:**
  - Payer program arrangements are set by Medicare in the Participation Agreement
  - As a new ACO in 2023, Lore Health's first shared savings/losses information will be available from CMS in the second half of 2024

Recommendation 2

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- **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.

- **Key Points:**
  - The ACO is making payments to Vermont providers and paying for in-kind incentives for Vermont beneficiaries
  - The budget numbers on the previous slide are estimates that assume 5% SS. Actual SS/SL will not be known until mid-2024

Recommendation 3:

- **Recommendation 3:** Lore Health provides to GMCB its quality reporting, segmented for Vermont if possible, with appropriate restrictions to protect patient confidentiality.

- **Key Points:**
  - ACOs report quality data to CMS at the close of each performance year, which CMS uses in determining SS/SL
  - CMS has standard methods to measure ACO quality performance
  - CMS requires ACOs to publish their performance on quality measures on the ACO's website

Section 5: Model of Care

- **Recommendation 4:** Lore Health provides a copy of the terms & conditions given to beneficiaries upon signing up for the Lore Health Platform, as well as any other marketing or informational materials shared with beneficiaries.
  - Lore Health shall notify the GMCB immediately if the intended use of beneficiary data changes from what Lore Health presented to the GMBC in connection with the review of Lore Health's FY23 budget. ~~on 10/24/22, then Gather Health must report any changes to the GMCB.~~ If no changes are reported to GMCB, Lore Health shall provide a certification under oath with the submission of its FY24 budget that no changes have been made to Lore Health's intended use of beneficiary data.
- **Key Points:**
  - Lore Health is a new ACO that will be testing a unique care model
  - Lore Health's care model includes a platform that beneficiaries will use

Section 5: Model of Care

- **Recommendation 5:** Lore Health provides a bi-annual update (first report submitted with FY24 budget submission on October 1, 2023) about how Lore Health'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. The development of the report template is delegated to ~~to be developed by~~ GMCB staff.

- **Key Points:**
  - Lore Health is a new ACO that will be testing a unique care model
  - Lore Health's care model includes a platform that beneficiaries will use

Recommendations Summary

- **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:** Lore Health provides to GMCB its quality reporting, segmented for Vermont if possible, with appropriate restrictions to protect patient confidentiality.
- **Recommendation 4:** Lore Health provides a copy of the terms & conditions given to beneficiaries upon signing up for the Lore Health Platform, as well as any other marketing or informational materials shared with beneficiaries.
  - Lore Health shall notify the GMCB immediately if the intended use of beneficiary data changes from what Lore Health presented to the GMBC in connection with the review of Lore Health's FY23 budget. If no changes are reported to GMCB, Lore Health shall provide a certification under oath with the submission of its FY24 budget that no changes have been made to Lore Health's intended use of beneficiary data.
- **Recommendation 5:** Lore Health provides a bi-annual update (first report submitted with FY24 budget submission on October 1, 2023) about how Lore Health'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. The development of the report template is delegated to GMCB staff.

Suggested Motion Language

- Motion language:

  Move that the GMCB approve Lore Health ACO's FY23 budget as submitted to the Board subject to the conditions reviewed by the Board today.

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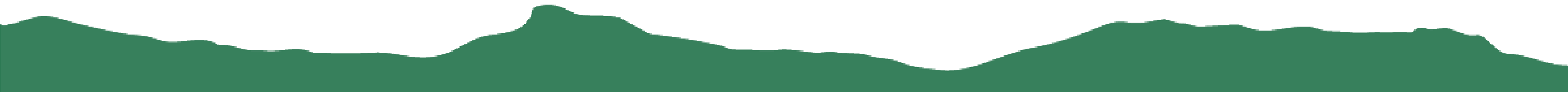
REFERENCE SLIDES



ACO Oversight Statute/Rule

- 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)

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

- 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.)

- 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

- ACO – Accountable Care Organization
- APM – All-Payer Model
- CMS – Centers for Medicare & Medicaid Services
- FFS – Fee-for-Service
- FY – Fiscal Year
- 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
- SNF – Skilled Nursing Facility
- SS/SL – Shared Savings/Shared Losses
- TCOC – Total Cost of Care