GMCB Staff and Board Questions for Lore Health

Re: FY2025 Budget Submission

Written Responses Due November 19 at 12:00pm EST

1. Appendix B – Program Arrangements
   Please provide the requested data in Cell E 20.

   Updated.

2. Section 3 Question 1
   Do you have the Vermont-specific results for Measure ID 479 for 2023? If so, please provide.

   Measure ID 479 is claims-based and calculated by CMS at the ACO level; it is not provided at a disaggregated (TIN or state) level.

3. Section 4 Question 2
   Please respond to the following prompt "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*"

   Our model focuses on providing ACO participants with additional information on their traditional Medicare patients to provide coordinated, high-quality care, delivered at the right time, to help beneficiaries explore what matters most to them in their health and life, and to connect beneficiaries with people like them who are doing the same.

   Based on our coordinated clinical efforts to improve the quality of care and access to care of beneficiaries, the ACO expects to realize savings in year 2 (PY2024). Because we are a Medicare-only ACO, Medicare remains the entity responsible for provider payment obligations. We maintain sufficient funds to support our care model and our administrative operations, with shared savings furthering that. We continue to build on our administrative infrastructure in support of these goals and are seeing trends that our actions are working.

4. Section 5 Question 2(c)
   Lore wrote "ACO participants are provided with information beyond their electronic health records on attributed beneficiaries" Is the information you are referring to ADT data or does the information include any other data types?

   This refers to CMS data to ACOs, including claims and other data for emergency department, inpatient admissions, and expenditures.

5. Appendix C – Financials
   Lore Health ACO experienced a 0.26% loss ACO-wide for 2023, which is represented in cell D16. Was the Vermont TCOC then 100.26% of the benchmark? Or did Vermont's performance vary from this 0.26% loss? (If Lore addresses this in their reporting due

November 8th, please disregard this question)

We do not receive a Vermont specific benchmark and cannot provide a calculation of shared savings or losses by state or individual ACO Participant. We can and do calculate and review ACO Participant expenditures, including how those expenditures change over time. It is important to note that final PY2023 and projected expenditures per participant in Vermont are presented as truncated per beneficiary per year dollars. While we do not know how other ACOs provide projections, we note that our ACO Participant's expenditures appear to be more efficient relative to other ACOs, reflecting the historical quality and skillset of our ACO Participant partner in managing the care and social needs of their patients.

6. Appendix C – Financials
   Lore Health ACO has described "in-kind incentives" that are part of the ACO's model of care. We would expect to see a value assigned to these incentives and any other incentives or non-shared savings going to Vermont providers or beneficiaries in cells D32, E32, and F32. If possible, please provide values and a description of what is included in these amounts.

   Medicare beneficiaries may access in-kind incentives such as healthy food. These are independent of the ACO's shared savings and losses and are for Vermont beneficiaries, not Vermont providers as a clarification to the question asked in D32-F32.

Additional Question for the Board Hearing 11/13

1. For each quality measure reported to CMS, please provide the ACO's target rate (goal) versus the ACO's performance in that measure for 2023.

The ACO's target in PY2023 was to successfully submit quality data on all patients served by ACO Participants to CMS and meet CMS' quality performance standard; this goal was met. Using 2023 results, the ACO is helping partners improve clinical processes and documentation related to quality goals. PY2024 will be another benchmarking year for Lore Health ACO because we are expecting to report on Medicare Beneficiaries only, not all patients regardless of payer. It is the first year for this type of reporting and CMS has not provided a benchmark for the quality measures for this type of reporting. Given this, our goal is to improve the actual performance in each measure. One additional note: nationally, the quality measure for depression screening and planning is topped out, meaning that a group has to score greater than 99.5% to be in the 70th percentile or higher. This is commonly seen when a quality measure gets automated in electronic health records and occurs independent of any human decision-making (error rate alone would create a lower level of performance). This is another reason we are focused on improving our actual performance.