Lore Health ACO LLC

Medicare Shared Savings Program

Performance Year 2024

Green Mountain Care Board Budget Analysis

Section 1: ACO INFORMATION, BACKGROUND AND GOVERNANCE

1. Date of Application: **October 2, 2023**
2. Name of ACO: **Lore Health ACO LLC**
3. Tax ID Number: XX-XXXXXXX
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): **LLC**
   b. In which Medicare Program the ACO is participating: **Medicare Shared Savings Program**
   c. Members of the governing body and their organizational affiliation (and identifying the designated Beneficiary member of the governing body and the Consumer Advocate):

      An up-to-date list of members of the governing body may be found on the ACO's website (current URL): www.lorehealthcare.com

   d. Officers of the ACO

      An up-to-date list of officers of the ACO may be found on the ACO's website (current URL): www.lorehealthcare.com

   e. Committee and subcommittee structure of the governing body, as applicable; and

      The ACO's governing body meets the requirements outlined by CMS at 42 CFR § 425.106 Shared Governance. The ACO also uses an ACO executive committee comprised of the ACO executive and three governing body members to address conflicts of interest and for governing body matters between meetings. The ACO's compliance officer reports directly to the governing body and does not serve as legal counsel to the ACO, consistent with 42 CFR § 425.300.

   f. Description of governing body's voting rules.

      The ACO's governing body voting requirements meet CMS regulations outlined at 42 CFR § 425.106 Shared Governance. The governing body's voting rules are available at www.lorehealthcare.com

5. Identify and describe each member of the ACO's executive leadership team, including name, title, tenure in current position, and qualifications for current position.

   The ACO's executive leadership team is available at www.lorehealthcare.com

   a. Does the ACO have any executive leadership compensation structure that is tied to reducing the amount paid for patient care? **No.**

6. 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. **None.**

7. 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. **None.**

8. If the ACO has been accredited, certified, or otherwise recognized by an external review organization (e.g., for EHNAC accreditation or payer assessments), submit the review organization's determination letter, associated assessment documents and results. If the ACO is working toward accreditation or certification, please describe. **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. **Please see attached.**

2 How many other states will the ACO operate in for 2024? **4**

3 What percentage of the ACO's attributed lives for 2024 will be in Vermont?

4 For ACOs that were operating in Vermont prior to 2024, complete Appendix A-2 to quantify the number and type of providers that have dropped out of the network starting in either the prior calendar year if the ACO was operating in Vermont during 2022, or 2023 if the ACO was operating in Vermont at this time, and to the best of your knowledge, their reasons for exiting; **Please see attached.**

5 For provider contracts 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.
   b. The cap on downside risk assumed by the provider, if any.
   c. What risk mitigation requirements does the ACO place on providers, if any (e.g., reinsurance, reserves).

6. Submit the template of the ACO's provider contract to GMCB.

7. Does the ACO have plans to expand their provider network in Vermont in future years?

   If yes, please describe the ACO's recruitment strategies.

   a. Describe the ACO's recruitment strategy and criteria for accepting providers into the network.

   b. Describe the ACO's outreach strategy and contact methods (phone calls, mailings, in-person outreach, etc.).

   c. Are there any differences in your approach to independent versus hospital-owned practices?

d. What is the ACO's network development timeline and contracting deadline?

e. Are there any challenges to network development?

If no (the ACO is not planning to expand in future years in Vermont), explain why.

While the ACO remains open to additional Vermont providers aligned with our commitment and approach to improving patient health, we do not have plans to expand our provider network in Vermont at this time.

Section 3. ACO PAYER PROGRAMS

1. 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 2024 contracts not available, please submit as an addendum when signed.

Please see the ACO Participation Agreement (CMS-Lore Health MSSP ACO Participation Agreement 2023.pdf) and ACO Change of Name Addendum (A5192 MSSP Change-of-Name Agreement.jp.pdf) submitted on 1/25/2023. This agreement began 1/1/2023 for a 5-year term through 12/31/2027.

2. Provide a completed Appendix B –2022 ACO Program Elements. **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).

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 or health of aligned beneficiaries.

The Medicare Shared Savings Program uses trended, risk-adjusted historical spending to create an ACO benchmark.

To be eligible for shared savings, the ACO must meet the SSP overall quality performance standard. For 2024, per 42 CFR § 425.512, the ACO will meet the quality performance standard based on:

> **(1) Achieving a health equity adjusted quality performance score that is equivalent to or higher than the 40th percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, or**
>
> **(2) If the ACO reports the three eCQMs/MIPS CQMs in the APP measure set, meeting the data completeness requirement and the case minimum requirement for all three eCQMs/MIPS CQMs, achieving a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four 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 one of the remaining five measures in the APP measure set.

The three eCQM/MIPS CQMS are:

- **Quality ID: 001 – Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9% HbA1c);**
- **Quality ID: 134 Preventive Care and Screening: Screening for Depression and Follow-up Plan;**
- **Quality ID: 236 Controlling High Blood Pressure.**

CMS also reviews administrative claims and determines:

- **Quality ID: 479 Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible MIPS Clinician Groups; and**
- **Quality ID: 484 Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions.**

CMS calculates the ACO's health equity adjusted quality performance score as the sum of the ACO's MIPS Quality performance category score for all measures in the APP measure set and the ACO's health equity adjustment bonus points calculated as below. The sum of these values may not exceed 100 percent.

CMS calculates the ACO's health equity adjustment bonus points as follows:

(i) For each measure in the APP measure set, CMS groups an ACO's performance into the top, middle, or bottom third of ACO measure performers by reporting mechanism.

(ii) CMS assigns values to the ACO for its performance on each measure as follows:

(A) Values of four, two, or zero for each measure for which the ACO's performance places it in the top, middle, or bottom third of ACO measure performers, respectively.

(B) Values of zero for each measure that CMS does not evaluate because the ACO does not meet the case minimum or the minimum sample size for the measure.

(iii) CMS sums the values assigned to the ACO to calculate the ACO's measure performance scaler.

(iv) CMS calculates an underserved multiplier for the ACO based on the following:

> **(A) CMS determines the proportion ranging from zero to one of the ACO's assigned beneficiary population for the performance year that is considered underserved based on the highest of:**
>
> **(1) The proportion of the ACO's assigned beneficiaries residing in a census block group with an Area Deprivation Index national percentile rank of at least 85; or**
>
> **(2) The proportion of the ACO's assigned beneficiaries that are enrolled in the Medicare Part D low-income subsidy (LIS); or are dually eligible for Medicare and Medicaid.**

If the proportion determined is lower than 20 percent, the ACO is ineligible for health equity adjustment bonus points.

CMS calculates the ACO's health equity adjustment bonus points as the product of the measure performance scaler determined and the underserved multiplier. If the product of these values is greater than 10, the value of the ACO's health equity adjustment bonus points is set equal to 10.

If the ACO is in a savings position, the ACO's shared savings rate is 75%, assuming it meets the quality performance standard or health equity adjusted quality performance score. If the ACO is in a loss position, the ACO's shared losses rate is determined by the 1 minus the product of 75% and the ACO's health equity adjusted quality performance score. The ACO's shared loss percentage may range between a minimum of 40% and maximum of 75%.

5. 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.

The ACO's first performance year is 2023. CMS will share 2023 performance year results in the second half of 2024.

6. Describe the current or proposed methodology used for beneficiary/member alignment (also known as attribution).

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).

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.

The ACO's first performance year is 2023. CMS will share 2023 performance year results, including final financial and quality results, in the second half of 2024. The ACO does not have audited financial statements or publicly available quarterly financial reports.

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.

Funds Flow

From	To	Payment Type (Funds)	Notes
CMS	Providers (All providers regardless of ACO participation)	Fee-for-Service	CMS pays providers 100% of submitted/approved fee-for-service claims.
ACO	Attributed beneficiaries	In-Kind Incentives	The ACO pays for and provides in-kind incentives, allowed under 42 CFR § 425.304, to improve beneficiary health.
CMS/ACO	ACO/CMS	Shared Savings and Shared Losses	The ACO maintains the contract with CMS for all shared savings and shared losses. In the event of shared savings, shared savings will flow from CMS to the ACO.
ACO	Providers (ACO providers only)	Shared Savings	In the event of shared savings, the ACO will pay shared savings to the ACO provider at the contracted amount.

3. If the ACO is taking risk of loss, provide a narrative explaining how the ACO would manage the financial liability for 2023 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 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.

All ACO participants are Medicare participants that submit claims to, and are paid by, CMS. ACO participants are paid by CMS at the approved fee-for-service claim amounts for all CMS beneficiaries, regardless of a beneficiary's attribution to any ACO.

Sitting on top of the general Medicare FFS payment structure, the ACO holds a Medicare Shared Savings Program (SSP) risk contract with CMS and holds the risk of loss. Given the SSP contract and program structure, there are multiple risk mitigation mechanisms in place for both CMS and the ACO.

The first risk mitigation mechanism is every SSP ACO must establish a repayment mechanism, or financial guarantee. CMS determines the repayment mechanism amount (e.g., financial guarantee) that the ACO must establish in order to participate. CMS sets that repayment mechanism amount based off of its experience with program performance and ACO losses. The ACO has established a repayment mechanism in accordance with CMS regulations and CMS calculations for CMS to issue a demand letter against in the event of shared losses.

The second risk mitigation mechanism is establishing a minimum savings rate (MSR) and minimum loss rate (MLR). The ACO has selected a 0.5% MSR/MLR, which means if savings or losses are 0.5% or less, no payment is made in either direction.

The third risk mitigation mechanism is CMS truncates claim experience at the 99th percentile for each of the four benchmarks (ESRD, disabled, aged/dual, and aged/non-dual), creating a *de facto* stop loss mechanism in both the benchmark and the performance year. By removing the top 1% of claims from each of the four benchmarks and the performance year, CMS' benchmark and the ACO's risk reflects less catastrophic claims expense and more of a standardized distribution.

The combination of these mechanisms has resulted in consistent performance for the Shared Savings Program and its participants. On August 24, 2023, CMS released results for 2022 that SSP achieved $1.8B in shared savings while covering 11M original Medicare beneficiaries with 573,000 participating clinicians. CMS found ACOs provided statistically significantly higher performance for quality measures related to diabetes and blood pressure control, breast cancer and colorectal cancer screening, tobacco screening and smoking cessation, and depression screening and follow-up.

In 2022, CMS reports that 405 SSP ACOs (84%) achieved shared savings, with an average savings rate of 4.81% (Range: 0-18.2%) and 77 SSP ACOs (16%) had shared losses, with an average loss rate of 1.88% (Range: 0 - -7.5%, with 1 outlier at -15.3%).

The ACO operates in the ENHANCED track of the Shared Savings Program. If the ACO achieves savings above the minimum savings rate, CMS shares 75% of the savings with the ACO and retains 25%. The most this 75% share may equate to is 20% of the ACO's total performance year benchmark. If the ACO shares losses, CMS will calculate the product of 75% and the ACO's health equity adjusted quality performance score. The shared loss rate will be 1 minus the above product, and must be between 40-75% of losses. The total dollar amount of losses is capped at 15% of the performance year benchmark.

If the ACO has shared losses in 2024, as determined in June/July 2025, CMS would issue a demand letter against the ACO's established repayment mechanism and then the ACO would be liable for any additional monies owed.

4. Provide any further documentation (i.e. policies) for the ACO's management of financial risk that provide additional context or support of the narrative response to question 3 above. **Not applicable.**

5. Complete **Appendix C – Financials** for 2024 and all past years the ACO has operated in Vermont as actuals or estimates as necessary. In addition to the Appendix, describe:

a. The proportion of shared savings invested in infrastructure, redesigned care processes, and other resources necessary to improve outcomes and reduce Medicare costs for beneficiaries on a total ACO-wide basis; and

b. The proportion of shared savings distributed to providers on a total ACO-wide basis, with breakouts for different provider types if applicable.

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, etc.) that informs the ACO's model, programs, and processes.

Our ACO's care model and approach to population health directly aligns with CMS' and the Vermont Blueprint for Health's focus on health equity and addressing social determinants of health, supporting patients' management of chronic diseases, helping patients understand resources available to them, and enhancing their experience with the care system.

Lore Health allows people to better understand and focus on preventing and reversing the chronic diseases that 60% of U.S. adults, inequitably skewed to poorer and minority communities, live with. (CDC, National Center for Chronic Disease Prevention and Health Promotion).

To enable that understanding and ultimately to decrease chronic disease burdens, as well as target addressable social determinants of health, our care model incorporates in-kind incentives for items and services that are not covered by Medicare and that are connected to the person's needed medical care. The set of in-kind incentives available to patients are evidence-based and enable the person to better understand, and have greater agency for, their health. Through the use of in-kind incentives people better understand their health and how their lifestyle may impact it.

We support coordination across the care continuum by helping people focus on lifestyle (e.g., nutrition, physical activity, sleep, stress management). With our ACO participant, the ACO works towards improving quality (e.g., CMS eCQMs) and other performance metrics to help in delivering value-based outcomes.

For 2024, pending CMS approval, we intend to implement a Medicare payment waiver that waives the requirement of a 3-day hospital stay prior to being able to utilize the skilled nursing facility benefit in FFS Medicare for ACO beneficiaries in Vermont. If granted, we believe this has the opportunity to improve patient quality of care through reducing emergency department and inpatient utilization as well as improve visibility and connection in post-acute care networks for patients with inpatient admissions.

The ACO has partnered with a Vermont provider that cares for patients with a broad set of both health and socioeconomic needs. Our partnership and work together includes applying generated savings to improve provider care infrastructure in delivering lifestyle medicine and improved care coordination.

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; **Lore Health Community**

        i. Describe the methods for prioritizing the initiatives; **Based on available scientific evidence for lifestyle improvements.**

        ii. List the major objectives for each initiative; **Educate and enable people to become their agents of change for lifestyle.**

        iii. List the outcome measures and key performance indicators for each initiative; **Improvements in Quality over time, (please see eCQMs); Improvements in Utilization over time.**

    b. Benefit enhancements or payment waivers offered; **In-Kind Incentives; 3-day SNF Rule Waiver.**

    c. How the ACO supports appropriate utilization of health care services by providers and patients; **The ACO tracks high and low utilization of services as part of on-going analytics. ACO participants are provided with information beyond their electronic health records on attributed beneficiaries, such as utilization to date, hospitalizations, and emergency department visits.**

    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; **The ACO supports providers and patients through making them aware of their Medicare benefits as well as in-kind incentives available to them through Lore.**

    e. Participation and role of community-based providers (e.g., designated mental health agencies, specialized services agencies, area agencies on aging, home health services, 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; T**he ACO participant maintains relationships with access navigators and others in the community to add resources for Vermont beneficiaries to understand how better to access care.**

    f. Integration efforts with the Vermont Blueprint for Health, regional care collaboratives and other state care coordination initiatives; **Our Vermont ACO participant has established access to Vermont HIE, integrating information from the HIE into their EHR and allowing them to identify ACO-attributed patients and specific care needs.**

g. Efforts that incentivize systemic health care investments in social determinants of health; and **The ACO has invested in an in-kind incentives program to allow people to understand their health and how their lifestyle impacts their health. All ACO beneficiaries have access to these additional resources, at no cost, as a way to support systemic change in patients' health and social determinants of health.**

h. Efforts that incentivize addressing the impacts of adverse childhood experiences and other traumas. **Our focus on lifestyle aims to decrease the on-going impacts of adverse childhood experiences and other traumas.**

3. Describe any strategies for expanding capacity in existing primary care practices, including but not limited to reducing administrative burden on such practices.

   We are intentional about reducing the administrative burden on our ACO participants so as to allow them to spend more time with patients. First, we reduce the administrative burden of individual practice quality reporting because the ACO reports specific quality metrics and the practice participates as an Advanced Alternative Payment Model (Advanced APM) for purposes of the Merit-based Incentive Payment System (MIPS). Second, we augment providers' ability to help their patients navigate and receive care, including by tracking patient's utilization, number of inpatient admissions, and emergency department visits.

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.

   Lore Health ACO in-kind incentives are accessible to all assigned Fee-for-Service beneficiaries, regardless of socioeconomic status. We also have accessibility and accommodation pathways for patients with limited digital literacy or without internet access to participate. By virtue of being an ACO, both the ACO and our provider partner are incentivized to bridge access and care equity gaps in the population we are responsible for. Bridging equity gaps for patients that want better health is core to the ACO and our provider partner, and by providing in-kind incentives, patients can access items and services that aim to narrow health equity gaps.

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

   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. **Our ACO participant has MAT providers that may help Vermont residents receive medication-assisted treatment.**

   b. Suicide: reduce the number of deaths due to suicide. **One ACO eCQM for 2023 and 2024 is Quality ID: 134 Preventive Care and Screening: Screening for Depression and Follow-up Plan.**

As the ACO and our partners work to improve screening and follow-up, we hope to help address depression in earlier stages.

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). **As noted in response (b), screening, identification, and follow-up is a critical quality measure for the ACO and the ACO participant. Patients with ED or inpatient use and depression are identified for the ACO participant to be able to intervene or refer as appropriate.**

d. Chronic Conditions: decrease the prevalence of COPD, diabetes, and hypertension for Vermont residents, reduce composite measure comprising of diabetes, hypertension, and multiple chronic condition morbidity. **The ACO's care model focuses on reducing the impact of chronic disease. Measures of performance for diabetes, hypertension, and other chronic disease management are a core part of tracking how the ACO is performing.**

e. Access to Care: increase number of Vermont residents reporting that they have a personal doctor or care provider, and increase percent of Vermont residents who say they are getting timely care, appointments, and information. **Medicare beneficiaries in fee-for-service have the option to voluntarily select a primary clinician that practices at our Vermont ACO participant partner. Patients of the provider partner will be provided information on how to voluntarily make that choice if it is right for them. Further, if the ACO has shared savings, additional resources will be available to our ACO provider partner to potentially expand access to care.**

f. Tobacco Use and Cessation: increase percent of Vermont residents who are screened for tobacco use and who receive cessation counseling intervention. **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 identifies beneficiaries with Asthma as well as emergency department and inpatient utilization.**

6. Please describe any referral program that the ACO employs to coordinate patient care, including home-based care providers and community-based providers.

   For FY 2024, as part of implementing the 3-day stay requirement for Medicare coverage waiver, the ACO and its provider partners will work to build processes that allow patients and providers to seek care at the right place, whether that is the hospital or a skilled nursing facility.

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?

   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. The ACO uses a

peer group of other SSP ACOs that use the same attribution model (Preliminary Prospective Attribution with Retrospective Reconciliation). The ACO uses this data to prioritize areas of greatest opportunity across ACO participants.

8. The GMCB expects to require FY24 reporting of Vermont performance data from the ACO a part of a FY24 budget approval. The reporting requirements will be finalized in the ACO's budget approval. The ACO should review the metrics listed on **Appendix - Tab D Performance Data** and justify any proposed deletions or additions to these metrics.

   CMS has established the performance data it requires across both quality and utilization for the Shared Savings Program. Given CMS and the ACO are aligned in reducing Ambulatory Care Sensitive Admissions and improving access to preventive care, our suggestion is to align any Vermont-specific reporting to CMS performance data for Medicare-only ACOs. If this recommendation is adopted, the GMCB would align with CMS and the ACO on the key quality metrics for ACO performance and would allow for a more targeted discussion of key areas.

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 meet 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: **Centers for Medicare & Medicaid Services Medicare Shared Savings Program**

Contract Period: **1/1/2023 – 12/31/2027**

Date Signed: **12/8/2022**

Financial Arrangement – Shared Savings and/or Shared Risk Arrangements

Are shared savings possible: **Yes**

Does shared savings agreement meet minimum requirements of 30% of the difference between actual and expected spending? **Yes**

Describe shared savings and shared risk arrangements: **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:

ACO Provider Agreement Reference(s): **Please see contract template provided on 9/29/2022.**

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
1. FFS-No link to Quality & Value	None	0%
2A: Foundational payments for infrastructure & operations	None	0%
2B: Pay for reporting	None	0%
2C: Pay for performance	None	0%
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%
4A: Condition-specific population-based payment	None	0%
4B with reconciliation to FFS and ultimate accountability for TCOC	Medicare AIPBP	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: **Please see below**

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: **Please see answer to Section 3, question 6.**

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/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?***
Hospital Inpatient Mental Health/Substance Abuse - Inpatient Maternity-Related and Newborns Surgical Medical	X
Hospital Outpatient Hospital Mental Health / Substance Abuse Observation Room Emergency Room Outpatient Surgery Outpatient Radiology Outpatient Lab Outpatient Physical Therapy Outpatient Other Therapy Other Outpatient Hospital	X
Professional Physician Services Physician Inpatient Setting Physician Outpatient Setting Physician Office Setting Professional Non-physician Professional Mental Health Provider	X
Post-Acute Care	X
DME	X
Dental	
Pharmacy	Part B pharmacy (physician-administered) only

*All categories are subject to CMS payment policies.

Table 3. Quality Measures

Quality Measure	**Included in Quality Measures?**
Screening for clinical depression and follow-up plan	Y
Tobacco use assessment and cessation intervention	N
Hypertension: Controlling high blood pressure (ACO composite)	Y
Diabetes Mellitus: HbA1c poor control (ACO composite)	Y
All-Cause unplanned admissions for patients with multiple chronic conditions (ACO composite)	Y
Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys*	Y
% of Medicaid adolescents with well-care visits	N
30-day follow-up after discharge from emergency department for mental health	N
30-day follow-up after discharge from emergency department for alcohol or other drug dependence	N
Initiation of alcohol and other drug dependence treatment Engagement of alcohol and other drug dependence treatment Risk-standardized, all-condition readmission	N
Skilled nursing facility 30-day all-cause readmission	N
Influenza immunization	N
Pneumonia vaccination status for older adults	N
Colorectal cancer screening	N
Number of asthma-related ED visits, stratified by age	N
HEDIS: All-Cause Readmissions	N
Developmental screening in the first 3 years of life	N
Follow-up after hospitalization for mental illness (7-Day Rate)	N
Falls: Screening for future fall risk	N
Body mass index screening and follow-up	N
All-cause unplanned admissions for patients with Diabetes	N
All-cause unplanned admissions for patients with Heart Failure	N
Breast cancer screening	N
Statin therapy for prevention and treatment of Cardiovascular Disease	N
Depression remission at 12 months	N
Diabetes: Eye exam	N
Ischemic Vascular Disease: Use of aspirin or another antithrombotic	N
Acute ambulatory care-sensitive condition composite	N
Medication reconciliation post-discharge	N
Use of imaging studies for low back pain	N
Add Additional Measures as Needed	N/A