Lore Health ACO LLC

Medicare Shared Savings Program

Performance Year 2025

Green Mountain Care Board Budget Analysis

Medicare-only ACO

Section 1: ACO INFORMATION, BACKGROUND AND GOVERNANCE

1. Date of Application: **October 1, 2024**
2. Name of ACO: **Lore Health ACO LLC**
3. Tax ID Number: *Redacted*
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 and track the ACO is participating; **Medicare Shared Savings Program; ENHANCED Track**
    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.lore.co/ACO**
    d. Officers of the ACO; **Same as above**
    e. Committee and subcommittee structure of the governing body, as applicable;

    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; (*See* Rule § 5.403(a)1, 18 V.S.A. § 9382(b)1(d))

    The ACO's governing body voting requirements meet CMS regulations outlined at 42 CFR § 425.106 Shared Governance. The governing body's voting is available at www.lore.co/ACO.

    g. List of reserved powers that are reserved to the owner, member, or sponsoring organization or that require approval by a subset of ACO board members. **N/A**

5. Describe the ACO's consumer input activities including any information regarding a consumer advisory board including charter and membership (*See* Rule § 5.403(a)5). **The ACO's current governing body is available at www.lore.co/ACO. The governing body meets requirements under 42 CFR 425.106, including the Medicare beneficiary representative requirement. Additionally, the ACO currently has a consumer advocate on the governing body.**

6. Describe the ACO's complaint, grievance, and appeal processes for providers and patients. (*See* Rule § 5.403(a)7). **Medicare-only ACOs do not have the authority to change Medicare fee-for-service benefits nor make coverage review determinations.**

7. 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 including any compliance issues. (*See* Rule § 5.403(a)6, 18 V.S.A. § 9382(b)1(d)) **None.**

8. 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. (*See* Rule § 5.403(a)6, 18 V.S.A. § 9382(b)1(d)) **None.**

9. If the ACO has been the subject of any reports from professional review organizations or payers, please attach said reports. (*See* Rule § 5.403(a)15, 18 V.S.A. § 9382(b)1(e)) **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. (*See* Rule § 5.403(a)8)

2. How many other states will the ACO operate in for 2025? Please list the other states. (*See* Rule § 5.403(a)8). **3; California, New Mexico, Florida**

3. What percentage of the ACO's attributed lives for 2025 will be in Vermont? (*See* Rule § 5.403(a)8) **~28%**

4. For ACOs that were operating in Vermont prior to 2025, complete **Appendix A-2** to quantify the number and type of providers that have dropped out of the network for all applicable years that the ACO was operating in Vermont, and to the best of your knowledge, their reasons for exiting; (*See* Rule § 5.403(a)8)

5. Does the ACO have plans to expand their provider network in Vermont in the next three years? (yes/no) (*See* Rule § 5.403(a)9). **No**

6. For all provider contract types 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; *Redacted*
    b. The cap on downside risk assumed by the provider, if any, and *Redacted*
    c. What risk mitigation requirements does the ACO place on providers, if any (e.g., reinsurance, reserves). (*See* Rule § 5.403(a)9) *Redacted*
    d. The amount of any withhold revenue for each provider *Redacted*

7. Submit the template of the ACO's provider contract(s) to GMCB. (*See* Rule § 5.403(a)9). **Please see the template ACO participant contract provided previously.**

Section 3: ACO PAYER PROGRAMS

1. 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.

   Measure ID 001: 38.7%
   Measure ID 134: 35.5%
   Measure ID 236: 66.6%
   Measure ID 479: 0.16%

   Vermont-specific: *Redacted*

2. 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 2025 contract is not available, please submit as an addendum when signed. (*See* Rule § 5.403(a)10).

   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.

3. Provide a completed Appendix B – 2025 ACO Program Arrangements and Elements (*See* Rule § 5.403(a)2, (a)10, (a)11, (b)1). **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). (*See* Rule § 5.403(a)9, (a)10).

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, patient satisfaction, or health of aligned beneficiaries. (*See* Rule § 5.403(a)11)

In sum, the ACO's financial performance requires the ACO be accountable for the health of aligned beneficiaries as measured through performance year expenditures, for the quality of care the aligned beneficiaries receive, as measured by the quality performance standard, and understanding patient satisfaction as measured by the CAHPS survey administration. The ACO participates in the ENHANCED Track and is governed by the benchmarking policies outlined at 42 CFR 425.610. The The quality performance standard is outlined at 42 CFR 425.512.

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. (*See* Rule § 5.403(a)2, (a)3)

   The ACO's first performance year is 2023. CMS has stated it will share 2023 performance year financial results in October 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. (*See* Rule § 5.403(a)1, (a)3; 18 V.S.A. § 9382(b)1(d))

   Funds Flow

From	To	Payment Type (Funds)	Notes
CMS	Providers	Fee-for-Service	CMS pays providers 100% of submitted/approved fee-for-service claims.
Redacted	*Redacted*	*Redacted*	*Redacted*
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 2025 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 and the amount of 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. (*See* Rule § 5.403(b)2, (b)3)

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 FFS payment structure, our 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 in order 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. CMS has not released data for 2023 as of this submission.

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 (est. $48M). 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 (est. $36M).

If the ACO has shared losses in 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.

The SSP contract is between the ACO and CMS.

4. Complete **Appendix C – Financials** for 2025 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, operations, 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. (*See* Rule § 5.403(a)2, (a)3; 18 V.S.A. § 9382(b)1(M))

5. Does the ACO have any executive leadership compensation structure that is tied to reducing the amount paid for patient care? (*See* Rule § 5.403(a)3; 18 V.S.A. § 9382(b)1(D), (b)1(M)) **No.**

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, evidence based clinical pathways, etc.) that informs the ACO's model, programs, and processes. (*See* Rule § 5.403(a)11)

The ACO's model of care is rooted in how people can improve their everyday health. The ACO partners with ACO Participants to augment the care that they provide for their patients. The American Association of Family Practice quotes that 75% of primary care visits include mental or behavioral health components (see Integrating Behavioral Health Into Primary Care). The CDC shows that emergency department (ED) visits require more care, by time, for patients with mental health disorders than without mental health disorders. Overall, the ACO works with ACO Participant partners to provide an additional set of resources to patients as they work on their everyday health.

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; (*See* Rule § 5.403(a)11) **Lore Platform**
        i. Describe the methods for prioritizing the initiatives; **Based on available scientific evidence surrounding chronic systemic inflammation and behavioral change.**
        ii. List the major objectives for each initiative; **Reduce chronic systemic inflammation and enable people to become their agents of change.**
        iii. List the outcome measures and key performance indicators for each initiative; **Improvements overtime in quality, cost, and satisfaction; provider and consumer feedback.**
    b. Benefit enhancements or payment waivers offered; (*See* Rule § 5.403(a)11); **In-kind Incentives**
    c. How the ACO supports appropriate utilization of health care services by both providers and patients; (*See* Rule § 5.403(a)13; 18 V.S.A. § 9382(b)(1)(A)) **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.**

    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; (*See* Rule § 5.403(a)18; 18 V.S.A. § 9382(b)(1)(H), (b)(1)(P)) **The ACO supports providers and patients through making them aware of their Medicare benefits as well as the availability of the Lore Platform.**

    e. Participation and role of community-based providers (e.g., designated mental health agencies, specialized services agencies, area agencies on aging, home health services, community service organizations, 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; (*See* Rule § 5.403(a)16; 18 V.S.A. § 9382(b)(1)(F))
    The ACO and the ACO's participant provider partner have actively established relationships with access navigators and others in the community to add resources for seniors to understand how better to access care. The ACO provides the option for all ACO-attributed beneficiaries to join Lore.

f. Integration efforts with the Vermont Blueprint for Health, regional care collaboratives and other state care coordination initiatives; (*See* Rule § 5.403(a)16; 18 V.S.A. § 9382(b)(1)(F)) **Our ACO Participant partner 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. A leader from our partner also staffs and facilitates the Springfield Health Service Area.**
g. Efforts that incentivize systemic health care investments in social determinants of health; (*See* Rule § 5.403(a)19) and **Assigned ACO beneficiaries have the option to earn in-kind incentives to help with health-related social needs of their choosing and prioritization.**
h. Efforts that incentivize addressing the impacts of adverse childhood experiences and other traumas. (*See* Rule § 5.403(a)20) **Lore may help people reflect on their health and everyday mental health in a private, non-judgmental way.**

3. Describe any strategies for expanding capacity in existing primary care practices, including but not limited to reducing administrative burden on such practices. (*See* Rule § 5.403(a)17)

The ACO provides our ACO Participant partner with additional resources and support, including shared savings, that it can use to expand capacity. Further, the ACO minimizes administrative tasks for all ACO Participants in order to allow the ACO Participant to devote resources towards its patients and additional staff. Further, the ACO's care model augments primary care practices by empowering people to make necessary behavior changes with the help of their own agency and the support of a community of others. By having people support one another, primary care practices can focus on acute priorities, like transitions of care, while chronic disease management can be augmented through the help of an always-accessible, no cost community.

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. (*See* Rule § 5.403(a)22)

Lore makes allowable in-kind incentives available to assigned fee-for-service beneficiaries that choose to engage with Lore. As we provide in-kind incentives, patients can meet specific health-related social needs to further health equity needs. For example, a person may purchase healthy food or health-related items. The ACO's goals are to provide in-kind incentives to all patients who are interested and desire them.

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

[1] *See page 51 of* State of Vermont All-Payer ACO Model Agreement Extension (Signed 2022), *available at* https://gmcboard.vermont.gov/document/amended-and-restated-vermont-all-payer-model-agreement-extension-signed-2022

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 provider partner currently operates a MAT program. Patients may join Lore and discuss their use of opioids and other treatment modalities for chronic pain.

b. Suicide: reduce the number of deaths due to suicide. **The ACO monitors its performance on Measure ID 134 to track depression screening and if an appropriate follow-up occurs. The intention is to improve screening and follow-ups in order to 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 and complications 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 is focused on everyday health to improve chronic disease and mental health. Measures of performance for diabetes, hypertension, and other chronic disease management are a core part of tracking how the ACO and shared community are performing.**
e. Access to Care: increase number of Vermont residents reporting that they have a personal doctor or primary care provider and increase percent of Vermont residents who say they are getting timely care, appointments, and information. **If the ACO is successful in helping Medicare Beneficiaries to improve their health, quality performance, and reduce costs, ACO Participants will have additional resources to provide timely care to Vermont residents. The ACO also serves as a source of information for patients if they choose.**
f. Tobacco Use and Cessation: increase percent of Vermont residents who are screened for tobacco use and who receive cessation counseling intervention. **ACO Participants provide 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 works to make patients aware of their Medicare benefits, including access to approved medication therapy management programs from their Medicare Part D plan. Further, emergency department utilization is an area that ACO tracks and provides to ACO Participants.**

6. Please describe any referral program that the ACO employs to coordinate patient care, including home-based care providers and community-based providers. (*See* Rule § 5.403(a)18)

The ACO has partnered with a local community-based organization to help patients access care. Our ACO Participant partner has resources to connect patients to community- or home-based care providers, when deemed appropriate.

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? (*See* Rule § 5.403(a)22)

   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 also works to understand how assigned beneficiaries access in-kind incentives across its participants, tracking how well the ACO and providers are connecting with them. The ACO uses this data to prioritize areas of greatest opportunity across ACO Participants.

8. Explain the ACO's quality evaluation and improvement program. Describe any improvement efforts the ACO focused on for FY25 and provide rationale for these efforts. (*See* Rule § 5.403(a)12)

   For FY25, the ACO is focused on improving quality outcomes specific to diabetes, hypertension, and depression screening and follow-up. The ACO is also tracking overall utilization, inpatient utilization, emergency department utilization, and access to in-kind incentives designed to improve beneficiary health.

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 meets 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: Click or tap here to enter text. **Contract Period**: Start Date to End Date **Date Signed**: Click or tap here to enter text.
Financial Arrangement – Shared Savings and/or Shared Risk Arrangements
Are shared savings possible? * **Yes**
Does shared savings arrangement meet minimum requirements of 30% of the difference between actual and expected spending (see Section 6.b of the All-Payer ACO Model Agreement)? * **Yes**
Describe shared savings and shared risk arrangement(s): **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: **Redacted**
ACO Provider Agreement Reference(s): **Please see contract template.**
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**	
Category 1: FFS-No link to Quality and Value			
1: FFS-No link to Quality & Value	None	0%	
Category 2: FFS-Link to Quality and Value			
2A: Foundational payments for infrastructure & operations	None	0%	
2B: Pay for reporting	None	0%	
2C: Pay for performance	None	0%	
Category 3: APMs Built on FFS Architecture			
3A: APMs with shared savings	None	0%	
3B: APMs with shared savings and downside risk	Medicare Shared Savings Program ENHANCED Track	100%	
3N: Risk based payments NOT linked to quality	None	0%	
Category 4: Population-Based Payment			
4A: Condition-specific population-based payment	None	0%	
4B: Comprehensive population-based payment	None	0%	
4B with reconciliation to FFS and ultimate accountability for TCOC	**Medicare AIPBP (Per CMMI and LAN)**: *CMMI actually includes VT All payer in the Annual LAN APM measurement effort and currently categorizes VT All payer as Category 4B (See definition from the LAN's APM Framework):*	0%	

	"Payments in Category 4B are prospective and population-based, and they cover all an individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct."		
4B with NO reconciliation to FFS	**Medicaid**	0%	
4C: Integrated finance & delivery system		0%	
4N: Capitated payments NOT linked to quality		0%	

Services Included in Financial Targets (Total Cost of Care)
Services Included in Financial Targets: *Complete **Appendix A, Services Included in Financial Targets**, for all ACO-payer contracts. (Services must be comparable to All-Payer Financial Target Services as defined in section 1.f of the All-Payer ACO Model Agreement, to qualify as Scale Target ACO Initiative)* ***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.): Quality performance standard; please see above answers.
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: Preliminary prospective with retrospective reconciliation
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?** ***(X or blank)***
Hospital Inpatient	X
Mental Health/Substance Abuse - Inpatient	X
Maternity-Related and Newborns	X (if eligible)
Surgical	X
Medical	X
Hospital Outpatient	X
Hospital Mental Health / Substance Abuse	X
Observation Room	X
Emergency Room	X
Outpatient Surgery	X
Outpatient Radiology	X
Outpatient Lab	X
Outpatient Physical Therapy	X
Outpatient Other Therapy	X
Other Outpatient Hospital	X
Professional	X
Physician Services	X
Physician Inpatient Setting	X
Physician Outpatient Setting	X
Physician Office Setting	X
Professional Non-physician	X
Professional Mental Health Provider	X

Post-Acute Care	X
DME	X
Dental	
Pharmacy	Part B physician-administered only

Table 3: Quality Measures

Indicate with "x" if category is included in the ACO's Medicare Program:

Quality Measure	**Included in Quality Measures?** ***(X or blank)***
Screening for clinical depression and follow-up plan	X
Tobacco use assessment and cessation intervention	
Hypertension: Controlling high blood pressure (ACO composite)	X
Diabetes Mellitus: HbA1c poor control (ACO composite)	X
All-Cause unplanned admissions for patients with multiple chronic conditions (ACO composite)	X
Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys*	X
% of Medicaid adolescents with well-care visits	
30-day follow-up after discharge from emergency department for mental health	
30-day follow-up after discharge from emergency department for alcohol or other drug dependence	
Initiation of alcohol and other drug dependence treatment	
Engagement of alcohol and other drug dependence treatment	
Risk-standardized, all-condition readmission	
Skilled nursing facility 30-day all-cause readmission	
Influenza immunization	
Pneumonia vaccination status for older adults	

Colorectal cancer screening	
Number of asthma-related ED visits, stratified by age	
HEDIS: All-Cause Readmissions	
Developmental screening in the first 3 years of life	
Follow-up after hospitalization for mental illness (7-Day Rate)	
Falls: Screening for future fall risk	
Body mass index screening and follow-up	
All-cause unplanned admissions for patients with Diabetes	
All-cause unplanned admissions for patients with Heart Failure	
Breast cancer screening	
Statin therapy for prevention and treatment of Cardiovascular Disease	
Depression remission at 12 months	
Diabetes: Eye exam	
Ischemic Vascular Disease: Use of aspirin or another antithrombotic	
Acute ambulatory care-sensitive condition composite	
Medication reconciliation post-discharge	
Use of imaging studies for low back pain	
Add Additional Measures as Needed	

Appendix 1. Lore Health FY24 Budget Order Condition 5 Questions

One of the conditions placed on Lore Health's FY24 ACO Budget by GMCB was for Lore Health to provide "a semi-annual update about how Lore's care model is working in Vermont, including any consumer complaints (not limited to Vermont beneficiaries). The development of the report template and a deadline is delegated to GMCB staff." *See* Lore Health FY24 ACO Budget Order, Condition 5.

The below questions must be completed by Lore Health ACO to satisfy the above condition.

1. Summarize how Lore Health's second year operating in Vermont has been transpiring. Describe what aspects of operation, patient engagement, quality and financial outcomes went as planned, as well as any aspects that did not. Described how this second year has differed from the first.

CMS has not finalized 2023 Medicare Shared Savings Program Performance Year results as of September 2024. Initial Performance Year 2024 data reflects largely the same trends as seen in available Performance Year 2023 data and is reflected in the financial submission assumptions.

Quality data for Performance Year 2023 for Vermont showed - Redacted

Overall, Lore Health ACO's second year has transpired consistent with our April 2024 updates.

2. What lessons have been learned from Lore Health's first 18+ months as an ACO? How will these lessons impact operations in FY25 and beyond? Are any of these observations Vermont-specific rather than ACO-wide? If so, please explain.

Lore Health ACO continues to work towards CMS' Shared Savings Program objectives of promoting accountability for a patient population, coordinating items and services under Medicare parts A and B, and investing in infrastructure and redesigned care processes for high quality and efficient services. We have not observed any Vermont-specific lessons.

3. Please include a report of all complaints/grievances filed by any Medicare beneficiaries regarding Lore Health ACO since the filing of Lore's second semi-annual report in April 2024. This report should denote any complaints from Vermont beneficiaries.

   Redacted

Note: For the below questions, the term "Platform" refers to the Lore mobile application platform.

For the purposes of these questions, "AI" and "AI system" are used interchangeably to refer to the artificial intelligence systems defined in 3 V.S.A. § 5021. Any system as defined in that section, whether implemented as a learning system or as a pre-trained model, is AI for the purpose of these questions.

4. How many Vermont beneficiaries from 2023 to present have signed up for the Lore Health Platform? How many Vermont beneficiary accounts have been deleted during this time?

   Redacted

5. Does Lore track engagement with the Platform? If so, describe how. Describe the level of actual engagement with the Platform among Vermont beneficiaries.

Redacted

6. How has the user experience in the Platform evolved in the past year? At what point was LoreBot introduced? What evidence did Lore have that use of interactive AI would benefit its users?

   Redacted

7. How does LoreBot respond to requests for medical advice? Describe any quality assurance process used to ensure that AI used by Lore is providing appropriate responses.

   LoreBot does not provide medical advice. Redacted.

8. How does LoreBot assess whether users are at risk of self-harm and/or suicide? If a user indicates suicidality, what does it advise the user?

   Redacted

9. How are patients informed that they are speaking with an AI system and not a real person when they use LoreBot?

   Every feature of LoreBot, from its name to how it is introduced to a user, is to inform a person that they are using a chatbot and not speaking to a real person. Whenever LoreBot is asked what it is or if it uses artificial intelligence, it confirms it is a bot that uses artificial intelligence. It will also refer people for support with a real person.

10. Can network providers access the messages patients send to LoreBot? Do network providers have access to LoreBot's responses? Do network providers receive metadata, summaries, or reports detailing patient communications with AI systems used by Lore?

    Redacted

11. Identify the following in regard to LoreBot:
    a. The commercial entity/entities that developed LoreBot.
    b. The entity/entities that administer patches or updates to LoreBot.
    c. The entity/entities that deploy LoreBot for the use of Lore Health and its network.
    d. All data sources used to train LoreBot in its understanding and use of solution-focused brief therapy (SFBT).
    e. The entity/entities responsible for data security monitoring of LoreBot.

    Redacted

12. Does Lore, or another entity identified in Question 10, have the right to sell patient data that is gathered through LoreBot?

    No.

13. Identify and briefly describe all existing data use agreements concerning either the Platform or LoreBot to which any entity identified above is a party.

Neither Lore Health ACO nor Lore Health LLC have any data use agreements with other companies to sell data. No party has the right to sell any data generated from Lore Health ACO or Lore Health LLC.

14. Identify and briefly describe all privacy and/or health data end user agreements required for use of Lore's mobile application and/or use of LoreBot.

All end user agreements have been developed to comply with applicable federal, state, and local regulations. Lore Health LLC and Lore Health ACO do not sell data. The Terms of Use and Privacy Policy are available at https://community.lorehealthcare.com/terms-of-use and https://community.lorehealthcare.com/privacy, respectively.

15. In addition to LoreBot, identify Lore Health's use of any other AI in its mobile application.

Redacted