Gather Health ACO LLC

Medicare Shared Savings Program

Performance Year 2023

Green Mountain Care Board Budget Analysis

Section 1: ACO INFORMATION, BACKGROUND AND GOVERNANCE

1. Date of Application: **September 29, 2022**
2. Name of ACO: **Gather 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. 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: https://www.gather.health/about)

   c. Officers of the ACO

An up-to-date list of officers of the ACO may be found on the ACO's website (current URL: https://www.gather.health/about)

   d. 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 will also have 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.

   e. 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 https://www.gather.health/about

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 https://www.gather.health/about

   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 NCQA 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.

2. For ACOs that were operating in Vermont prior to 2023, complete Appendix A-2 to quantify the number and type of providers that have dropped out of the network 2021-2023 (prior, current, and budget years) and to the best of your knowledge, their reasons for exiting. **Not applicable.**

3. 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. **None**
b. The cap on downside risk assumed by the provider, if any. **Please see attached template.**
c. What risk mitigation requirements does the ACO place on providers, if any (e.g., reinsurance, reserves). **Not applicable.**

4. Submit the template of the ACO's provider contract to GMCB. **Please see attached template.**

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

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

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

The ACO seeks providers that are committed to practicing lifestyle medicine and helping patients achieve their goals in a community. Recruitment criteria is for providers that are Medicare-enrolled, accept fee-for-service beneficiaries, are aligned with the ACO's care model, and are committed to providing high-value care for Medicare beneficiaries.

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

The ACO employs a multi-channel outreach strategy which includes in-person conversations and introductions and phone calls following warm introductions or interest from providers.

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

We currently work with both independent and hospital-owned practices. Our primary aim is to support providers move to value-based care models to ensure there are reimbursement mechanisms for the lifestyle and other high-value care they provide.

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

For 2024, the ACO will add providers between now and the CMS deadline for 2024 (For reference, the 2023 SSP performance year deadline was August 4, 2022).

e. Are there any challenges to network development?

Our ACO care model focuses on providers committed to helping their patients make lifestyle changes. As our ACO participants share their results and experience, we expect our network to largely develop organically.

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 2022 contracts not available, please submit as an addendum when signed.

The Shared Savings Program signing event, where the participation agreement is executed, for the 2023 performance year is in December 2022. The ACO will submit an addendum when the participation agreement is executed.

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 2023, per 42 CFR § 425.512, the ACO will meet the quality performance standard based on reporting ten CMS Web Interface measures or three eCQMs/MIPS CQMs and the CAHPS for MIPS survey. For 2024, to meet the quality performance standard, the providers in the ACO must be equal or higher than the 40th percentile across all MIPS Quality performance categories.

If the ACO has shared losses, the shared loss rate is adjusted by the ACO's quality performance. The shared loss rate will be between 75% of losses (not to exceed 15% of the final performance year benchmark) and 40% of losses, based on the ACO's MIPS performance points earned divided by available MIPS points available (e.g., if the ACO achieves 90% of available MIPS points, its shared loss rate is determined by the following steps: 1. Calculate the ACO's performance and multiple by the 75% max (90% x 75% = 67.5%); 2. Subtract this from 100% to determine the shared losses rate applied (100% - 67.5% = 32.5%). 3. Apply the lower bound, if applicable. (e.g., the shared losses must be 40% or higher). Because the shared losses cannot be less than 40%, the ACO would be responsible for paying 40% of shared losses.

More information is available here, including the example on pp 48-49: https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-and-losses-and-assignment-methodology-specifications.pdf-1.

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).

More information is available here in 2.3.2.1 and Appendix B: https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-and-losses-and-assignment-methodology-specifications.pdf-1

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 and other ACO financial results in the second half of 2024.

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	Providers (ACO providers only)	Payments	Payments to fund high-value care deliver and care coordination.
ACO	Patients	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. In the event of shared losses, shared losses will flow from the ACO to CMS.
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.

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.

First, contractually, the ACO holds the risk contract with CMS. All ACO participants are still Medicare participants that submit claims and are paid by CMS 100% of their approved fee-for-service claim amounts for assigned ACO beneficiaries.

The ACO then contracts with its ACO participants and those contracts determine the amount of shared savings and shared losses (please see provided contract for these terms).

Second, there are multiple risk mitigation mechanisms in place for both CMS and the ACO that have resulted in relatively positive performance for both CMS and ACOs in the Shared Savings Program.

The first risk mitigation mechanism is every SSP ACO must have a repayment mechanism, or financial guarantee. CMS determines the repayment mechanism amount (e.g., financial guarantee) that the ACO must have in order to participate. CMS sets that repayment mechanism amount based off of experience with 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 claims 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 the benchmark. By removing the top 1% of claims from the benchmark, CMS' benchmark reflects less stochastic randomness and more of a standard distribution.

The combination of these mechanisms has resulted in consistent performance for the program and its participants. On August 30, 2022, CMS released results for 2021 that SSP achieved $1.66B in shared savings, covering 11M original Medicare beneficiaries and 525,000 participating clinicians. 99% of ACOs reported and met the quality standard to share in savings, with 58% earned payments based on performance above the designed MSR/MLR. This is consistent with 2020 results, when $2.3B in shared savings were paid by CMS, with 88% of two-sided risk ACOs earning shared savings and 55% of one-sided risk ACOs earning savings, based on performance above the MSR/MLR.

Assuming an ACO performance year benchmark of $225,000,000, the ACO's maximum savings is 20%, or $45M, and the loss band is $18M-$33.75M (8-15% losses, depending on quality performance). If the ACO has shared losses in 2023, as determined in June/July 2024, 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.

More information is available here in Section 3 and Section 4:
https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-and-losses-and-assignment-methodology-specifications.pdf-1

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. Please provide the following information for 2021-2023, as an estimated budget:

a. The amount of any fixed payments and any shared savings distributed to Vermont Participant Providers and Preferred Providers: **Not applicable.**

b. The amount of any shared savings or shared losses on a total ACO-wide basis. **Not applicable.**

c. 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: **Not applicable.**

d. The proportion of shared savings distributed to Participant Providers and Preferred Providers on a total ACO-wide basis: **Not applicable.**

Section 5: ACO MODEL OF CARE AND COMMUNITY INTEGRATION

1.Describe the ACO's Model of Care, including but not limited to how it may address:

a. All population health initiatives

b. Benefit enhancements offered

c. Support for appropriate utilization of health care services

d. Support for 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

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

f. Integration efforts with the Vermont Blueprint for Health, regional care collaboratives and other state care coordination initiatives

g. Efforts that incentivize systemic health care investments in social determinants of health

h. Efforts that incentivize for preventing and addressing the impacts of adverse childhood experiences and other traumas.

Our ACO's care model and approach to population health directly aligns with the Vermont Blueprint for Health's and the Centers for Medicare & Medicaid Services' focus on addressing social determinants of health, supporting patients' management of chronic diseases, helping patients understand resources to reduce their costs, and enhancing their experience with the care system.

We do this through the use of an always-accessible shared community of providers and patients to address the suite of mental and physical health issues faced by both the patients and providers we partner with. Our community is intentionally designed to 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 feedback loops that support behavior change, 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.

We support coordination across the care continuum, which promotes appropriate utilization of care, through technology (e.g., VHIE), dedicated focus on lifestyle medicine (e.g., nutrition, physical activity, sleep, stress management), and specific health interventions such as medication therapy management (e.g., Beers list criteria, poly-pharmacy, gaps in adherence and care), access to palliative care and advance care plans, and information and referrals for caregivers and interventions to support people with ADL impairments better aging in place (e.g., the Vermont Adult Services Division).

Further, through integrating with the Vermont HIE and VITL, as well as working with our provider partner, we intend to support patients and providers with structured transitions of care, including what to do before a non-urgent ED or in-patient hospital admission, where possible, as well as for patients that transition back to the community. This will include working with our provider partner on the right connection points for post-acute care partners, like skilled nursing facilities or home health agencies.

The ACO has partnered with a Vermont provider that cares for patients with a broad set of health needs. Our partnership and work together includes both upfront investment in provider care infrastructure to deliver lifestyle medicine and better care coordination, as well as on-going sharing of generated savings.

2. 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 administrative burden on our ACO participants to allow them to spend more time with patients. First, we reduce the administrative burden of quality reporting because the ACO reports specific quality metrics and the practice participates as an Advanced Alternative Payment Model (Advanced APM) in Medicare for purposes of the Merit-based Incentive Payment System (MIPS). Second, we augment providers' ability help their patients navigate and receive care, ranging from helping people find referrals for their social determinants of health needs or better access their prescription drugs, medication therapy management, and medication reconciliation, to identifying patients that are undergoing a transition of care and working to help them transition safely, in the right setting, to reduce unnecessary re-admissions.

Further, the ACO's care model augments primary care practices by empowering people to make necessary behavior changes with the support of a community of other patients and providers. By having people support one another, primary care practices can focus on acute priorities, like transitions of care, while chronic disease management can be managed with the help of an always-accessible community.

3. How is the ACO addressing health equity concerns? If the ACO has specific goals in this area, describe any specific actions the ACO is taking to achieve these goals.

By virtue of being an ACO, both the ACO and our provider partner are incentivized to bridge access and care equity gaps in the populations we manage. Specifically, we will work through our population and identify patients without advance care plans, without primary care visits, and other targeted high-value care. We will engage these patients in culturally-competent ways to invite them and coordinate solutions to overcome any barriers to access (e.g., financial, logistics, transportation, etc). Bridging equity gaps for patients that want better health is core to the ACO and our provider partner.

4. Does the ACO have any specific programs or initiatives intended to improve performance on any of these measures? For additional information about the measures, please see Appendix 1 of the State of Vermont All-Payer ACO Model Agreement.

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 provider partner currently operates an MAT program.**

b. Suicide: reduce the number of deaths due to suicide. **The ACO will track depression screenings for the ACO population as well as medication use and access.**

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 part of the care transitions process, the ACO will work with the ACO's participant partner to identify patients with an ED visit for mental health and then create a screening and follow-up plan.**

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 is to focus on these chronic diseases as well as other chronic diseases related to mental health through a shared community and technology. 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 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.**

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 ensures patients have access to Medicare-approved medication therapy management programs from Medicare Part D plans as well as access to targeted medication reviews by the ACO.**

5.Describe the evidence (such as peer reviewed studies, past performance, etc.) that informs the ACO's programs and processes, including point of care systems, population health efforts, and referral practices.

The two evidence bases we pull from are the impact of shared medical appointments (SMAs) and the use of telehealth as a care modality.

SMAs include more than one patient and may be with a provider or a provider plus a facilitator. The sessions are 60-120 minutes and allow for a broader social interaction, shared advocacy, and safe education space in ways that one-on-one visits may not. Kirsh et al postulated nine main mechanisms that serve to explain the impact of SMAs in chronic disease:

(1) Group exposure in SMAs combats isolation, which in turn helps to remove doubts about one's ability to manage illness; (2) Patients learn about disease self-management vicariously by witnessing others' illness experiences; (3) Patients feel inspired by seeing others who are coping well; (4) Group dynamics lead patients and providers to developing more equitable relationships; (5) Providers feel increased appreciation and rapport toward colleagues leading to increased efficiency; (6) Providers learn from the patients how better to meet their patients' needs; (7) Adequate time allotment of the SMA leads patients to feel supported; (8) Patients receive professional expertise from the provider in combination with first-hand information from peers, resulting in more robust health knowledge; and (9) Patients have the opportunity to see how the physicians interact with fellow patients, which allows them to get to know the physician and better determine their level of trust.[1]

This framework is useful in understanding how the ACO's care model of an always-accessible community of patients and providers focused on chronic disease and behavior change can impact the support a person feels in achieving their health goals.

We augment the data and evidence on SMAs with the data and evidence from telehealth, especially post-COVID-19. Data showed Medicare beneficiaries are able to adopt new modalities of care quickly, as seen in the 63-fold increase from 840,000 telehealth visits in 2019 to 52.7M in 2020.[2] **As equity of access to internet and data increases, and the right communities exist for patients and providers to interact in, chronic disease management, care referrals, and transitions of care will all improve.**

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[1] Kirsh, S.R., Aron, D.C., Johnson, K.D. et al. A realist review of shared medical appointments: How, for whom, and under what circumstances do they work?. BMC Health Serv Res 17, 113 (2017). https://doi.org/10.1186/s12913-017-2064-z

[2] U.S. Department of Health & Human Services. Medicare Beneficiaries' Use of Telehealth in 2020: Trends by Beneficiary Characteristics and Location. December 3, 2021.

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

Specifically:

a. Describe how providers access the referral program information;

b. How do providers select to whom they make referrals? What information does the ACO supply to providers when evaluating referral options for both in-and out-of-network providers?

Medicare beneficiaries in the ACO retain the right to seek care from any care provider that accepts Medicare. The ACO works with our ACO participant partner to identify current referral patterns and care capabilities, including for post-acute care and transitions of care, and then making patients and providers aware of the quality results and capabilities of relevant providers.

7.Does the ACO benchmark performance measures against similar entities? If no, explain why not. If yes, in what areas 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. For example, the ACO has domains for in-patient and emergency utilization, medication over- and under-use, medication adherence, and gaps in care, to name some. The ACO also establishes benchmarks for engagement and how well the ACO and providers are connecting with assigned patients.

Appendix A. https://gather.health/about Page Information as of September 29, 2022

ACO Name and Location

Gather Health ACO LLC

101 West Broadway, 9th Floor

San Diego 92101

Primary contact

Mark Briesacher, MD

Email: mbriesacher@gather.health

Organizational Information

ACO Participants	ACO Participant Type
B&H HEALTH SERVICES INC	ACO professionals in group practice arrangements
COLLIERVILLE PEDIATRICS LLC	ACO professionals in group practice arrangements
EMBEE LIFESTYLE DOCS PLLC	ACO professionals in group practice arrangements
FIRST CHOICE COMMUNITY HEALTHCARE, INC	FQHC
INFLAMMATION MEDICAL GROUP	ACO professional
IRENE MALEK MD PROFESSIONAL CORPORATION	ACO professionals in group practice arrangements
NEIGHBORHOOD HEALTHCARE	FQHC
SOHAM PATEL MD PA	ACO professional
SPRINGFIELD MEDICAL CARE SYSTEMS INC	FQHC
USC CARE MEDICAL GROUP INC	ACO professionals in group practice arrangements

*No participants are in joint ventures between ACO professionals and hospitals.

ACO Governing Body

Member	Organizational Affiliation	Voting
ACO Advocates, Beneficiary, and Executive		**25% Total**
Mark Briesacher, MD (ACO executive)	Gather Health ACO LLC	
Pastor Michael Moore, Sr. (Beneficiary Advocate)	Founder, Agapemo. Paster at Encounter Church (San Leandro, CA)	
Paula Branson, JD, NBC-HWS (Beneficiary Advocate)	Advocate for Lifestyle Medicine	
ACO Beneficiary (TBD Assignment)	*Medicare Beneficiary*	
ACO Participants		**75% Total**
Adam Ameele, Psy.D.	Springfield Medical Care Systems	
Munish Chawla, MD	Embee Lifestyle Docs	
Scott Durgin, MD	Springfield Medical Care Systems	
James LaBelle, MD	Inflammation Medical Group	
Mark Malek, MD	Irene Malek MD Professional Corp	
Frederick (Rick) Miller, MD	First Choice Community Healthcare	
Jennifer Pentecost, MD	First Choice Community Healthcare	
Jim Schultz, MD	Neighborhood Healthcare	

Governing Body Associated Committees and Committee Leadership

Governing Body Committee	Committee Leadership
ACO Executive Committee	Mark Briesacher, MD

Key Clinical and Administrative Leadership

ACO Executive Director: Mark Briesacher, MD

Compliance and Quality Assurance Director: Mark Atalla, PharmD

Senior Medical Director: Jim LaBelle, MD

Data and Community Director: Sara Taylor, PhD

Shared savings and losses information

The ACO's first performance year is 2023.

Quality Measure Performance

The ACO's first performance year is 2023.

Use of payment rule waivers under § 425.612, if applicable, or telehealth services under § 425.613, if applicable, or both.

SNF 3-day rule waiver: No

Telehealth Services: No