PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

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Owen Foster
Chair, Green Mountain Care Board
144 State Street, Montpelier, VT 05602

Dear Chair Foster and Members of the Green Mountain Care Board,

Thank you for allowing additional time for the public to learn more about Vytalize Health 9's request to extend its ACO REACH Model into Vermont, and to provide comments on this development.

Vermont Physicians for a National Health Program strongly supports the goals of Act 48. Board members Drs. Jane Katz Field, MD, Vice President; Ted Cody, MD, ScD, Secretary; and Marvin Malek, MD, MPH, member at-large, have also submitted comments. I am listing here several principles from Act 48, in italics and highlighted in gray, most relevant to this conversation.

My requests:

1) Extend the time for public comment, and provide more transparency by making more documents accessible, including

- those submitted to CMS that were part off the credentialing process
- records that explain where Vytalize expects that $1 million to come from: how much from capitation fees; how much from processes that reduce spending on medical care; and how much from other sources, which should be explicitly named
- what processes will be used to reduce medical spending, and how that will look operationally from the perspective of patients, clinicians, and other clinic staff
- explicit statements about Vytalize's goals
- records explaining the "claw back" if Vytalize doesn't meet its goals

so that the public can participate meaningfully with their comments.

2) Accept the authority granted by the Vermont legislature to oversee our health care system to the fullest extent possible. The Center for Medicare and Medicaid Services does not have the responsibility to Vermonters that the Board has, and does not appear to be acting on behalf of Vermonters who have paid into FICA withholding and are expecting the funds to be managed responsibly and sustainably.

3) Do not approve this budget based on the materials that Vytalize has submitted so far.

4) Consider what measures the Board might recommend to the executive and legislative branches for stabilizing primary care clinics with strategies that align with the principles in Act 48.

5) Consider what policies can be implemented to protect individuals' health information from use beyond what patients may understand.

6) Consider the input of clinicians in innovations contemplated for Vermont health care. Physicians across the state in the Vermont Medical Society recommend against adding private equity into the mix.

7) Provide more information to the public about the range of possibilities GMCB is pursuing; the ramifications for individuals, providers, Vermont's health care system, as well as national ramifications; and how these possibilities stack up next to the responsibilities with which GMCB was tasked.

Selected sections of Act 48

I have selected and italicized sections of Act 48 that are relevant to this request from Vytalize, and highlighted them in gray. I have highlighted excerpts from the Vytalize application in blue. My comments follow.

Sec. 1.

a. *...It is also the intent of the general assembly to maximize the receipt of federal funds..*

It appears that this proposal from Vytalize will **maximize the receipt of federal funds but primarily to itself;** typically the model overcharges Medicare relative to what the patients' health care would have cost if they were not in the Model, and indeed, Vytalize expects to make $1 million off of funds collected from working Americans through FICA withholding, which goes to Hoboken, NJ. I am not aware that the state will receive any of the federal funds maximized. **It is essential that contracts and a more specific budget are available for public scrutiny so we can see how much is going to sustain our clinics, how much is going to administrative waste, and how much administrative burden will be placed on our providers**.

Sec. 1a.

(2) Overall health care costs must be contained…
(6) Vermonters should be aware of the costs of the health services they receive. Costs should be transparent and easy to understand.

(10) Vermont's health care system must include mechanisms for containing all system costs and eliminating unnecessary expenditures, including by reducing administrative costs and by reducing costs that do not contribute to efficient, high-quality health services or improve health outcomes. Efforts to reduce overall health care costs should identify sources of excess cost growth.
(11) The financing of health care in Vermont must be sufficient, fair, predictable, transparent, sustainable, and shared equitably.

ACO REACH programs do not contain costs. They can be expected to reduce expenditures on health care, but they can be expected to dramatically increase overall costs to the health care system.

We have every expectation that our FQHCs are actually very efficient and provide high quality care. We have little reason to think that Dr. Amer Alnajar has much to teach our clinicians on this. And given the track record of CMS and CMMI in the past few years, we have no reason to expect CMS's certification as a vetting process does anything to improve the chances that we will have better outcomes. Vytalize should be able to easily provide to the GMCB the materials they have already written up for CMS, and the vast majority of those materials should be able to be made public. **The cost of implementing a program needs to include the cost to the clinic, including staff and clinician time learning new software, updating their training at the expected intervals, and entering data beyond what they normally would have entered.**

Additional costs that are not mentioned in the Vytalize presentation are the cost to patient data privacy, and the damage to the patient-provider relationship when provider behavior is incentivised by a for-profit corporation.

Typically, these schemes privatizing Medicare involve charging Medicare a fee per person aligned with their model. They gather data on patients to make them look sicker, to get a higher capitation fee. They mine the patients' medical records, even for long-inactive problems, and send health workers to visit them at home to seek opportunities to find or exaggerate diagnoses. In addition to ransacking the Medicare trust fund, this is an invasion of privacy and a violation of the intent of HIPPA laws. Patients sign off saying their health information can be shared to help them in their clinical care, or as necessary for billing. Historically, that meant for billing when you received a service, or for documentation that you had received a service for which you or an insurer are being billed. **A patient typically would not understand that they are signing off on an insurance corporation or similar entity gaining access to their entire past medical history, nor should they be asked to give that broad of access.**

Given that the FQHCs provide care to entire communities, not just Medicare beneficiaries, GMCB must ensure that the data collection that is put in place for those in this Model is not then implemented for all patients, violating privacy for patients who are not in this model.

(4) Primary care must be preserved and enhanced so that Vermonters have care available to them, preferably within their own communities.

Dr. Homan's letter is particularly moving. She writes about the challenges Little Rivers faces in continuing to provide care, with the bank declining to extend their line of credit, and notes: *"If we had a health care system that was even moderately sane in how it funded primary care, we would not have to make this choice."*

Primary care clinics in rural, low-income areas should have global budgets with predictable payments. Capitation does not capture the fact that less densely populated areas will not reap economies of scale but still need to maintain a minimum of essential health services.

(5) Every Vermonter should be able to choose his or her health care providers.

(8) The health care system must recognize the primacy of the relationship between patients and their health care practitioners, respecting the professional judgment of health care practitioners and the informed decisions of patients.

Medicare beneficiaries who chose traditional Medicare are legally supposed to have access to any doctor that participates in Medicare. However, patients do not know the provider community of specialists, and are dependent on recommendations from their primary care providers. In Medicare Advantage, the patient knows this when they sign up, and they can look over the list. The idea that doctors might steer patients toward some doctors over others based on a financial incentive, and those relationships are not known by the patient, is unconscionable.

In the document labeled "Medicare Only Guidance Vytalize Health 9 ACO LLC", in response to this question:

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.

Vytalize provided this response:

Providers are participating in the ACO REACH Model for 2024

Perhaps Appendix A-1 has been filled out, but I am not seeing it. Lacking more detailed information, I can only expect that it is likely Vytalize will prefer that clinicians refer to a "shadow" network, in which there is an unpublished network that is financially advantageous to Vytalize. I want to see what incentives are offered, and what penalties physicians might face in this contract year or in a subsequent contract year if they refer to different providers.

Alarmingly, in that same document, Vytalize writes this:

b. Portion of the risk delegated through fixed payment models to ACO-contracted providers;

- *Vytalize does not pass risk to providers.*

But then states this:

> *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.);*
>
> - *Practices with significant losses in a Performance Year may be subject the following year to certain clawbacks of funds advanced during the Performance Year.*

For the protection of our health care infrastructure - both facilities and workforce - we need to know what those clawbacks look like.

Also in the document "Medicare Only Guidance Vytalize Health 9 ACO LLC," Vytalize writes:

> *Our goal with network development is to establish a strong primary care base within a given geography that represents sufficient density to support effective care coordination within a network of specialists, ancillary and post-acute providers. The challenge is in creating that density.*

I am perplexed, given the concern about the need for density for their "effective care coordination" to succeed, why they are expanding into rural Vermont, and that statement highlights the question regarding to whom the clinicians will be expected to refer.

> *(12) The system must consider the effects of payment reform on individuals and on health care professionals and suppliers.*

I think we can assume that the legislative intent would include that Medicare is a supplier of funds for health care, and our regulatory Board must consider the effect of payment reform on the Medicare trust fund as well as on individuals and providers.. GMCB is tasked with

> *[enabling] health care professionals to provide, on a solvent basis, effective and efficient health services that are in the public interest.*

This company has a lot of resources at its disposal to ensure they put forth a contract that protects their profit goals, and may well have hidden risks. Their fiduciary responsibility is to their investors, and they do not have any responsibility to the sustainability of health care access in Vermont nor to the economic viability of our communities.

> *(9) Vermont's health delivery system must seek continuous improvement of health care quality and safety and of the health of the population and promote healthy lifestyles. The system therefore must be evaluated regularly for improvements in access, quality, and cost containment.*

Data collection for patient care and de-identified data collection for research for improving outcomes is laudable, but the plan for this must be driven by an entity with the public good as its priority.

I would like to refer you to an older document, which laid out some of our problems back in 2016 and continues just as relevant today:

- "Primary Care: The Path Forward" was written by eight physicians practicing in FQHC's in Vermont, including two at Little Rivers. Getting involved with an ACO REACH is going in the opposite direction from the path forward they urged.

I would also like to refer you to the resolutions adopted by the Vermont Medical Society on April 19 and November 8, 2023, in direct response to what clinicians have had to deal with over the years since "value-based care" came into vogue.

Principles for the Development of Pay-for-Performance Programs

Addressing Ethical Dilemmas in Some of CMS's Pay for Performance and Value Based Care Programs

Medicare Advantage Program

Closing comments

"Value-based care" has not led to the cost-control and the improvements in quality that we had hoped for. We have learned a lot, and should act on the lessons we have learned and move on. We know that Americans actually use LESS health care than people of many other nations that have better outcomes. We need to get to the real problems in our health care system: PRICES. Lack of access to care (geographic, transportation, financial, etc). Long wait times for primary care and multiple specialties. Shortages in our health care workforce, with worsening shortages predicted.

I encourage GMCB to take a proactive role in developing a high-quality and efficient sustainable system.

Sincerely,

Betty J. Keller, MD
President, Vermont Physicians for a National Health Program
St. Johnsbury, VT