COMMENT ON VYTALIZE PROPOSAL TO ESTABLISH AN ACO REACH ENTITY IN VERMONT

I'm writing to encourage the Green Mountain Care Board (GMCB) to reject the budgetary submission of the Vytalize corporation of New York/ New Jersey, which is attempting to establish an ACO REACH entity in partnership with two FQHCs in Vermont. My comment is necessarily long, given the many facts that demonstrate Vitalyze's unsuitability. I ask the Board to read this comment with the same concern that prompted me to write it. Nothing in the history of Vytalize or its founders indicates that this company will be good for the Vermonters who count on the Board to advocate for the health of the people of our communities and the state as a whole.

Vytalize and its leadership

Vytalize's founders and dual CEOs are Amer Alnajar and Faris Ghawi.

Dr Alnajar completed medical school at Drexel University College of Medicine in 2012. He began residency training at Drexel University's Hahnemann Hospital in June 2012. He was dismissed from the residency program before completion due to dereliction of duty, lack of professionalism, and failure to sit for Step 3 of his Board exam by the Drexel program's deadline (Dec 2013). Alnajar sued to get his position restored, and won the case. However, Drexel appealed the decision, and the court's decision was reversed. Alnajar then appealed, but the decision not to restore his residency position was upheld.[i] That Drexel College of Medicine was willing to expend a good deal of money on legal expenses for this litigation with no financial reward in play speaks to how much they did not want Alnajar to return to the residency, doubtless due to the deficiencies mentioned above.

Alnajar was allowed to complete that year (year 2) of the residency, but was forced to leave the program at that point The American Board of Internal Medicine indicates that he is not Board Certified. This is consistent with the fact that he did not complete an internal medicine residency. Of interest is that in an interview with mHealth Intelligence, an online health tech newsletter, Alnajar states twice that he completed his Internal Medicine training.[ii] For this, there is no evidence. Rather than attempt to complete an internal medicine residency at a different residency program, in 2014, he moved to New York City and promptly founded a primary care internal medicine practice, and later added a second practice site in New Jersey. In 2016, his practice became part of an ACO operating in NYC. In 2019, he and Faris Ghawi co-founded their own ACO, and then in 2022 transitioned his ACO into a Direct Contracting Entity, and then an ACO REACH when the DCE program was rebranded in 2023.

Vytalize's other co-founder and co-CEO is Faris Ghawi. Ghawi's education culminates in an MBA degree. He has no medical or health care training or experience prior to his involvement with Vytalize.[iii]

Vytlize received $17 million in capital from Kittyhawk Ventures and Hudson River Capital in 2020, which allowed them to purchase MedPilot, a data management firm, and hire additional employees to facilitate Vytalize's expansion.[iv] In April 2022, Vytalize sought and received $55 Million from a private equity group led by Enhanced Healthcare Partners and Monroe Capital. They returned to those same private equity capital entities for an additional $100 Million in February, 2023.[v]

At their November 15, 2023 presentation to the GMCB, Vytalize's team indicated that an essential aspect of their model was to work closely with the medical staffs of their contracting primary care centers as they introduce their quality improvement / cost reduction strategies to each primary care team. However, they have apparently already negotiated a contract with Mountain Community Health, while members of the medical staff of the facility were unaware of Vytalize.[vi]

Vytalize's CEOs also mentioned that they routinely classify specialists into High or Low Performers. They thereby create a set of specialists to whom the primary care clinicians are supposed to preferentially refer. Vytalize has refused to disclose their provider contract, so we don't whether or how large the financial incentive may be to confine referrals to this "shadow" network[1]. The Vytalize team knows nothing of the practices of these specialists (a cardiologist specializing in pulmonary hypertension will generate more spending than a cardiologist specializing in non-invasive cardiology or arrhythmia treatment), and Alnajar will likely never meet any of the physicians he may be adding or excluding from his specialist network to find out what factors may be contributing to the cost and quality of his/her practice. Instead, their specialist panel is determined by a software program, Care Ventures.

Until Vytalize discloses its provider contracts to the public, the public will have no way to know:

1 If contracting providers receive a financial incentive to assist Vytalize with upcoding to increase their payments from Medicare

2 If contracting providers receive a financial incentive to confine referrals to Vytalize's specialty network

[1] In contrast to Medicare Advantage patients who are informed of the existence of a network, ACO REACH are not made aware that their primary care providers have a financial incentive to confine referrals to the ACO REACH's network

3 The magnitude of the incentive payment to contracting providers as a reward for reducing spending on their patient population.

When asked why they chose to locate in Vermont, Dr Alnajar stated that he values the opportunity to work with FQHCs and community health centers. Since he could instead have taken the subway back in NYC and found FQHCs awaiting him at many subway stops and saved the trouble of driving to Vermont, this statement appears to be dubious. it seems more likely that Vytalize is here in Vermont due to Vermont's relatively low Medicare Advantage penetration (MA patients are automatically excluded from the Medicare payments Vytalize and other ACOs and ACO REACH entities receive). And with over $100 million of debt owed to the private equity group that is providing Vytalize its capital, this company must expand—quickly. But all we heard from the Vytalize team is that they like FQHCs.

The ACO REACH program

ACO REACH is a value-based care model initially developed by the Trump administration and first implemented (under the "Direct Contracting Entity" brand) in 2021. It allows participation by most types of corporations—including private equity and other for-profit entities—in a bidirectional risk bearing payment structure compared to the usual CMS benchmark. The ACO REACH entity would negotiate the extent of risk that would be shared by contracting primary care providers, with at minimum 50% risk-based payments and capitated payment for the practice's traditional Medicare patient population.[vii]

Despite the well-documented overpayments CMS has been making to both Medicare Advantage and the value-based care plans being implemented for patients electing traditional Medicare [viii] [ix] [x], leaders within the Medicare program appear to be pushing ahead with the plan to enroll 100% of Medicare beneficiaries into such programs by 2030. Mindful of this development, the Vermont Medical Society unanimously adopted a resolution to be used in the evaluation of these plans.[xi] Many of them are directly relevant to the Vytalize applicant, and to the ACO REACH program in general.

<u>Some relevant clauses in the Vermont Medical Society resolution regarding Medicare's value-based care (VBC) programs:</u>

1 Patients should not be unwittingly or unwillingly enrolled in VBC programs

2 Information provided to Medicare beneficiaries about contractual payment relationships that their clinicians may enter with CMS or third party intermediaries should be reviewed by a Medicare ombudsperson, and important financial relationships in such contracts, including those that may create

disincentives to providing care, should be disclosed in language that lay persons would find to be readily understandable –

3 Programs should not impose ethical conflicts on participating clinicians, such as clinicians facing significant financial loss when their patients require costly procedures; and they should be designed to protect patient access to necessary care, especially patients with expensive, complex illnesses.

4 For profit corporations and private equity capital should be excluded from CMS's value-based care programs.

SUMMARY:

Vytalize is founded by a leadership group with very little medical or primary care experience, and questionable professional integrity. That they have elected private equity capital as their nearly exclusive source of financing will mean that any unforeseen setback would severely test whatever ethical compass they profess to adhere to.

The Vytalize group claims to have formulated an extraordinarily effective quality improvement program, which they work hard with clinicians to implement. The Vytalize team is conspicuously lacking clinical experience. This doesn't necessarily mean that their program isn't useful. But rather than take their word for it, it would seem appropriate for GMCB's Primary Care Advisory Group, or the primary care teams at Little Rivers and Mountain Community Health to evaluate the program, since they have vastly more clinical experience than Vytalize. Furthermore, all these primary care sites already have quality improvement programs in place, which would need to be integrated with the measures Vytalize expects them to implement. After emphasizing to the GMCB how important working with primary care providers is, it is striking that Vytalize has been willing to sign a contract with the clinic administration without speaking with the clinic providers.

Vermont's application for the AHEAD program—or other statewide cooperative VBC models--will be seriously undermined by balkanization of the original Medicare population by the entry of corporate VBC plans attempting to take advantage of CMS overpayments luring these clinics with kickback's from Medicare's overpayments.

The ACO REACH program imposes financial disincentives which will doubtless cultivate patient mistrust of their primary care clinicians. And to the extent that these contracts do impose financial losses for treating clinicians when their patients generate high medical costs, they are actually facing an ethical conflict, thereby justifying the mistrust. Because Vytalize refuses to disclose their provider contract, details of its financial arrangement aren't known. The Vytalize representatives stated that providers will not face financial sanctions, at least not in

the first year of the contract. Given the increasing prevalence of vaccine hesitancy, mistrust of medical experts, and conspiracy theories, this is hardly the time to create an actual financial structure that pits the economic well being of physicians against their patients when patients require expensive care.

The involuntary enrollment of patients and deceptive information patients are provided are completely unacceptable.

Based on the projected budget Vytalize presented, Vytalize expects to clear $1 million for their work with Vermont's two clinics. This amounts to $533 per patient. This $1 million will be exported from Vermont. In the ACO REACH system, all of the first 25% of spending that is less than the benchmark (misnamed "savings") goes to the ACO REACH. So neither the state of Vermont, nor the Medicare program will benefit financially if there are "savings". Clinics that sign up may receive a kickback from these savings, though if their patient population turns out to be sicker than expected, than the financial consequences to the clinic may be dire. On the other hand, if Vytalize doesn't come to Vermont, this $1 million will be used to pay Vermont's providers rather than being diverted outside our state.

CONCLUSION:

Allowing Vytalize, an indebted, private equity funded entity to operate in Vermont is neither in the best interest of our provider community nor our patients. Vytalize's application to contract with primary care practices, including FQHCs, should be summarily rejected by the Green Mountain Care Board. If the GMCB is unable to do prevent Vytalize from establishing itself in Vermont, it should at the very least inform Vermonters about what the program entails, and whether Vytalize has agreed to allow the public to review their provider contract.

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[iii] https://www.linkedin.com/in/faris-ghawi-2b938416/

[iv] https://www.prnewswire.com/news-releases/vytalize-health-to-acquire-medpilot-to-accelerate-data-driven-engagement-technology-to-its-acos-medicare-population-301231600.html

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[vii] https://www.cms.gov/priorities/innovation/innovation-models/aco-reach

[viii] Gilfillan, R and Berwick,DM; Medicare Advantage, Direct Contracting, and the Medicare 'Money Machine, Part 2: Building on the ACO Model. Health Affairs Blog, September30, 2021.

[ix] Livingston, S; Insurers profit from Medicare Advantage's incentive to add coding that boosts reimbursement. Modern Healthcare Sept 1, 2018

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