OneCare Vermont's EB-5 Moment

Against the backdrop of Vermont Legal Aid, a party to the All Payer Model ("APM") Agreement invoking anti-trust concerns on November 29, 2022,[1] it is appropriate to recount the many alerts along the way that forecast the GMCB's situation today.

Like Mike Pieciak finding himself responsible for the captive Agency of Commerce and Community Development, GMCB must examine the very real risks of delaying decisive action in reforming Vermont's All Payer Model. Where Pieciak's delay risked further loss of Chinese Yuan investments, here GMCB risks Vermont's public health by further inaction – to potentially catastrophic results.

GMCB members are well acquainted with the fundamental, systemic failures of OneCare VT. In fact, members first learned of the allegations of systemic fraud at OneCare Vermont ("OCV") over four years ago – in 2018, when a False Claims Act *qui tam* action was filed in Vermont District Court,[2] and the U.S. Attorney and VT AG, investigated the matter prior to their declination. As GMCB members are aware, the declination was not exculpatory for OCV. It instead resulted from OCV's regulators telling DOJ and the Vermont AG's office that they were aware of systemic failures but chose to continue funding OCV supposedly because the data analytics and care coordination relying on them were but a small part of what they paid OCV to do – as a breezeway for hundreds of millions of dollars in payer payments.

These representations to the DOJ and the AGO contradict the actions of deputy commissioner Michael Costa, who rubber stamped millions in DSR and HIT funds to OCV to prop it up starting in 2017. Months later, Costa coincidentally left DVHA, where he and current OCV CEO Vicky Loner were once colleagues, and joined her on OCV's board.

Consonant with Vermont Legal Aid's recent public suggestions to the GMCB, OneCare VT has not proved capable of providing "countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs." [3] Further, OCV representatives have confirmed and acknowledged that failing: OCV COO Sara Barry confirmed the same in her comments to GMCB on 11/9/2022, expressed more precisely still by OCV CMO Carrie Wulfman on 11/16/2022, and explicitly in OCV's second round question responses on 11/18/2022, OCV:

> *"is unable to report for the entirety of its population for hypertension control, A1c control, or related measures because* ***they require data which is either incomplete or unavailable****. Due to the clinical nature of these measures, manual chart abstraction or another clinical data source are required.* ***Manual chart abstraction for the whole OneCare network is not feasible and data sources such as VITL lack complete data for all of OneCare's population****."* (emphasis added) [4]

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[1] https://gmcboard.vermont.gov/sites/gmcb/files/documents/Health Care Advocate_Written Comments_OCV FY2023 Budget_11.29.2022.pdf

[2] USDC VT Case No.: 5:18-cv-126.

[3] 18 V.S.A § 9382.

[4] https://gmcboard.vermont.gov/sites/gmcb/files/documents/REDACTED%20FY%202023%20Budget%20Responses%20to%20Round%202%20Questions%2011-18-22.pdf

Since the 2018 Budget Submission hearing and follow-up hearing in fall 2017, OCV has represented that the $4.25mm they paid Vermont Information Technology Leaders ("VITL") from 2017 – 2021 – was money well spent to a reliable partner. Then-GMCB Chair Kevin Mullin repeatedly asked then-CEO of OneCare, Todd Moore, for reassurance that VITL would be able to deliver on the necessary clinical data that OCV has only this year finally acknowledged that it lacks.

But since January 2018, VITL, OCV and DVHA knew the VITL data couldn't be used, as confirmed by a clinical data quality analysis performed as part of the Vermont Medicaid Next Generation ("VMNG") program.[5] Less than half of A1c and Hypertension records were accurate and complete. Why does this matter? Because as OCV stated in their own application in 2017 for the Vermont Medicaid contract:

> *"OneCare Vermont understands **that care coordination within and across communities will rely heavily on creation of a functional statewide Health Information Exchange** with sharing of administrative and clinical data (medications, problems lists, image reports, lab results, etc.)"* (emphasis added).
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> And:
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> *"**Complex care coordination will be a key focus area at OneCare Vermont** and we will explore opportunities to develop new programs that target the most vulnerable populations in the network with innovative deployment of wrap around services for improved clinical and cost outcomes. Using sophisticated data analytics (refer to Health Informatics section), OneCare Vermont will provide participants with the ability to identify and manage high-need, high-cost beneficiaries with complex conditions…"* (emphasis added).

As former Chair Mullin was aware, VITL was essential to the all-payer experiment the state was about to launch. And yet, even GMCB's own Robin Lunge out of gross ignorance or negligence suggested to the public in 2019 that if VITL couldn't be improved, there was "only so much the state could do about it," without acknowledging how central this failure would be to the failure of the state's sole ACO.

Related to Vermont Legal Aid's concerns expressed over decommissioned analytics, the Care Navigator software that OCV uses for care coordination absolutely requires the clinical data OCV lacks. Even worse, the analytics software that OCV uses, Health Catalyst, essentially functions as a data warehouse expressly purposed to receive and combine claims data with VITL data specifically, rendering it useless: 90% of all data queries within and outside OCV queried UVMMC's legacy SQL server *instead of* OCV's own Health Catalyst.

Consequently: all the attributed lives claims data has been sitting in the UVMMC SQL server since 2018. So Vermont Legal Aid's anti-trust concerns over the data analytics contract are not new; they've always sat with UVMMC and OCV, confirmed as much at this year's 2023 budget hearing.

Presiding over all of this was then-Informatics Director at OCV, Leah Fullem, promoted in 2018 to VP at UVMHN, to find the Data Management Office to which OCV will now contract its analytics. It was under her lead of the EPIC implementation that it suffered catastrophic failure. And it has been known since 2018 that OCV's analytics would eventually migrate with Fullem due to systemic deficiencies. Over the same period, while working for UVMHN that wholly owned OCV, Fullem functioned as VITL's

[5] The VMNG Clinical Data Quality Analysis of VITL data was procured as part of a public records request to VITL in 2019.

chairwoman, while it receipted $800,000 annually from her current employer – monies all paid with taxpayer funds passed through OCV by DVHA.

And yet, in the 2023 budget season, there is finally now a concession that the crucial VITL data necessary for complex care coordination for diabetics, hypertension and depression patients, was not actually available, despite millions of dollars expended. At best, a statistical sample of select populations can be performed by OCV only once annually for the purposes of the annual scorecards. [6]

In reality, a viable ACO, through care coordination savings, can realize reduced higher-cost care through preventative care instead, by relying on the clinical EHR data that OCV now transparently concedes they lack entirely. This explains why member Murman cautions that declining ED utilization in the Burlington HSA is more likely attributed to well-documented declines in access to care rather than by any intervention attributable to the ACO.

Crucially, if OCV and GMCB published utilization rates as they once did, we would be able to see concurrent increases in utilization in primary and specialty care. But ever since OCV first published and DVHA was caught in the act of misrepresenting such rates, OCV has never since published them. [7]

When individuals ask what the correct measures are for success, they ignore that A1c, hypertension, depression, and suicide screening **are the clinical measures for a reason**. Nearly all the spending in the system is on these behaviorally-driven, chronic illnesses that metastasize into more complex, more comorbid, higher acuity, higher cost care. Addressing them is how we reduce rates in the claims measures related to utilization.

Since 2019, however, this board has ignored, panned, dismissed, and made fun of the care coordination analysis provided to it. In fact, public records requests of board members and staff demonstrate they were more concerned with the potential for their ACO to be destroyed than by diligently examining it. Not a single effort to this day has been made by GMCB to examine the underlying allegations it has been abreast of for 4 ½ years now.

Like Pieciak in 2015, GMCB is at a crossroads. Will it delay as Pieciak did for 9 months or more while OCV becomes further embroiled in controversy and failure? [8] Or will it act?

As GMCB member Lunge has commented publicly recently, GMCB "can't shut down the ACO." She knows, like all the hospitals writing in support of OCV this year – the ACO is now too big to fail. Tens of millions in payments made possible by the APM waiver must flow to hospitals through OCV.

'Too Big to Fail' has precedent. The federal government performed receivership for myriad banks and automakers in the wake of the Great Financial Recession. The Shumlin Admininstration essentially performed the same, only too late after receiving warnings of the risks of EB-5. In members Walsh and

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[6] See question 11:
https://gmcboard.vermont.gov/sites/gmcb/files/documents/REDACTED%20FY%202023%20Budget%20Responses%20to%20Round%202%20Questions%2011-18-22.pdf

[7] https://vtdigger.org/2019/10/06/health-care-reform-advocate-michael-costa-appointed-to-onecare-board/

[8] https://vtdigger.org/2021/06/24/would-be-whistleblower-sues-onecare-for-wrongful-termination/

Murman, the GMCB finally has qualified health care professionals in in its ranks. At this time, the public would call upon GMCB under Foster's leadership to place OneCare VT in receivership so that the unraveling of the health care system related to 'Too Big to Fail' is not realized, while the state navigates the system away from a monopoly as VLA identified it, that provides no **"countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs."**