Vytalize

September 27, 2023

VIA EMAIL: GMCB.ACO@vermont.gov; HCAPolicyTeam@vtlegalaid.org

Green Mountain Care Board
144 State Street
Montpelier, VT 005602

Re: Waiver Request & Deadline Extension for Vytalize Health 9 ACO LLC

Dear Green Mountain Care Board:

I am writing on behalf of Vytalize Health 9 ACO, LLC (Vytalize Health 9), a health care organization that is participating as an Accountable Care Organization (ACO) in the Centers for Medicare & Medicaid Services' (CMS) Realizing Equity, Access and Community Health (REACH) Model (REACH or the Model). Through our previous discussions with Michelle Sawyer, Green Mountain Care Board (GMCB) Health Policy Project Director, she confirmed that Vytalize Health 9, an ACO operating as a Medicare Only ACO, does not require certification by the GMCB as an ACO in Vermont but that certain other state statutes and rules may apply. Vytalize Health 9 requests a waiver of GMCB Rules 5.404(a) and 5.405(c)2, pursuant to Rule 5.601.

To the extent that a waiver is not issued pursuant to your discretion to do so, prior to the October 2, 2023, deadline for budget submission, Vytalize Health 9 respectfully requests an extension of the October 2, 2023, deadline in accordance with the provisions of Rule 5.601 and for the reasons identified below in the **Deadline Extension** section.

Vytalize Health 9 ACO, LLC

CMS accepted Vytalize Health 9 as a participant in REACH starting in the 2023 Performance Year, the first year of that model. Vytalize Health, LLC, as an organization, will operate two (2) Medicare Shared Savings Program (MSSP) entities and two (2) REACH entities encompassing 40 states in 2024. Vytalize Health 9 contemplates only two Vermont provider entities in 2024. As an organization dedicated to the value-based care model and improving the quality of life for both providers and patients, Vytalize Health 9 anticipates alignment of less than 2,000 Medicare beneficiaries in Vermont out of its almost 190,000 beneficiaries, representing roughly 1% of the overall beneficiary population.

Medicare Requirements under the REACH Model

As the GMCB understands, CMS required Vytalize Health 9 to submit an application demonstrating its ability to meet model requirements, from both a financial and operational perspective. CMS reviewed Vytalize Health 9's business model and reviewed the organization's prior experience in risk-based and outcomes-based agreements. Vytalize Health 9 demonstrated its ability to fund its REACH activity, including a plan for how it would support a program that drives better health, better health care, and lower costs. Vytalize Health 9 also showed how it will compensate its contracted providers and improve the care for its aligned beneficiaries.

Pursuant to the Participation Agreement with CMS (over 300 pages), a REACH entity must maintain all records of its operations (including financial and quality records) and make them available to CMS and other Federal agencies. Compliance for REACH entities begins with preparation of a compliance plan that must be reviewed and approved by CMS. CMS also audits REACH entities for compliance with all provisions of the Participation Agreement, which include receiving documentation directly from providers and interviewing providers and beneficiaries. Moreover, REACH entities and their providers are subject to ongoing program integrity review by CMS's Office of Program Integrity, the Department of Health and Human Services (HHS) Office of Inspector General, and the U.S. Department of Justice. REACH entities also must maintain a public website that includes contact information for a REACH executive as well as information relating to the REACH's performance on financial and quality metrics. In addition, REACH entities agree to strict enforcement by CMS, which ranges from warning letters and corrective action plans to termination of participation in the Model.

Rule 5.400 - Review of ACO Budgets and Payer Programs

GMCB Rule 5.400 sets out numerous requirements centered around an ACO's budget and related ability to successfully perform its duties in coordinating the provision of high value care to patients. Specifically, the GMCB requires its participation in, and approval of, an ACO's annual budget. ACOs must also annually provide documentation on its governance structure, financial operations, and care coordination activities. These requirements are, in large part, duplicative of the obligations placed on REACH ACOs by CMS. While Vytalize Health is mindful of the Office of the Health Care Advocate's position relating to a broad waiver request, as outlined in its response to Clover Health Partners, LLC (set forth below), Vytalize Health is not requesting a broad waiver as a result of being fully vetted by CMS in becoming a REACH ACO, rather Vytalize Health is requesting a narrowly tailored waiver, consistent with the tenets of Rule 5.601.

> We further note that the basis of Clover's request for a broad waiver of GMCB budgetary oversight is essentially that it is a Medicare only ACO. When the legislature set out the requirements for ACO budget oversight, it could have exempted Medicare only ACOs but did not. We therefore believe Clover's waiver request conflicts with 18 V.S.A. §9382 Oversight of Accountable Care Organizations.

In fact, pursuant to 18 V.S.A. §9382 b(2) the Green Mountain Care Board is specifically required to adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for reviewing, modifying, and approving the budgets of ACOs with fewer than 10,000 attributed lives in Vermont. As advised above, and in prior communications with the board, Vytalize Health 9 contemplates less than 2,000 Vermont attributed lives. The legislature allows the GMCB, in performing its review, to consider as many of the factors described in 18 V.S.A. §9382, subdivision (1) of this subsection **as the Board deems appropriate to a specific ACO's size and scope. (See also, Rule 5.405 (c)2)** As such, the Vytalize Health 9 waiver request is not in conflict with 18 V.S.A. §9382, rather it is consistent with that framework.

Moreover, a review of the letter from the Office of the Health Care Advocate in response to Clover Health's request for a broad waiver reveals that their primary purpose for urging the GMCB to reject the waiver request was related to the multiple investigations Clover Health was facing from government

agencies such as the Department of Justice, the Securities and Exchange Commission, and the New Jersey State Commission of Investigation into its business model, financial activities, leadership, and overall approach to providing health care related services, and not the fact that Clover Health was a Medicare Only ACO. Vytalize Health 9 is not and has not been the subject of any investigations or inquiries from any federal agencies and maintains an active compliance program.

Request for Waiver from Rules 5.404(a) and Rule 5.405(c)2

Vytalize Health 9 is operating solely as an ACO (as defined by 18 V.S.A § 9571 and Rule 5.103) under Medicare's REACH model and, therefore, is not required to be certified as an ACO by the GMCB under 18 V.S.A. § 9382(a) ("In order to be eligible to receive payments from Medicaid or commercial insurance through any payment reform program or initiative, including an all-payer model, each accountable care organization shall obtain and maintain certification from the Green Mountain Care Board.").

Vytalize Health specifically requests the GMCB waive the following requirements pursuant to Rule 5.601:

- Rule 5.404(a): Public Hearing
- Rule 5.405(c)2: Review Process

Waiver of these requirements is appropriate and necessary under Rule 5.601, which provides:

> In order to prevent unnecessary hardship or delay, in order to prevent injustice, or for other good cause, the Board may waive the application of any provision of this Rule upon such conditions as it may require, unless precluded by the Rule itself or by statute. Any waiver granted by the Board shall be issued in writing and shall specify the grounds upon which it is based.

Waiver of Rule 5.404(a)

Rule 5.404(a) provides that:

> The Board shall hold one or more public hearings concerning a proposed budget submitted by an ACO, **except that the Board may decline to hold a hearing concerning a proposed budget submitted by an ACO that is expected to have fewer than 10,000 attributed lives in Vermont during the next Budget Year or that will not be assuming risk during the next Budget Year. (emphasis added)**

Vytalize Health 9 is requesting a waiver of the public hearing and asking GMCB to exercise its discretion and decline to hold a hearing with respect to our proposed budget submission to prevent unnecessary delay in approving the budget before the end of the calendar year. Due to the nature of our overall waiver request and the delay anticipated in receiving a response from the GMCB regarding our waiver request, coupled with the extension of time (as requested below) needed to respond to GMCB's ultimate determination and the fact that Vytalize Health 9

anticipates less than 2,000 Vermont Medicare beneficiaries, good cause dictates the waiver of a public hearing.

Waiver of Rule 5.405(c)2

Vytalize Health 9 requests a waiver of the budget submission requirement of Rule 5.405(c)2 because of its approval by CMS as a REACH ACO combined with the fact that the less than 2000 Vermont lives contemplated within the ACO represents an opportunity for GMCB to exercise its discretion in limiting the redundancy and administrative burden of requiring that an approved Medicare ACO re-prove its ability to successfully operate an ACO. Specifically, since Rule 5.405(c)3 allows GMCB to review as part of the budget process the elements of the ACO's Payer-specific programs, and those requirements are largely duplicative of the factors addressed in Rule 5.405(c)2, a waiver of Rule 5.405(c)2 is consistent with preventing unnecessary hardship and supports the good cause provision of Rule 5.601. Clover Health sought a waiver of the entirety of Rule 5.400 on the basis that it was a Medicare Only ACO, while Vytalize Health 9 seeks only a waiver of a provision of the rule that is duplicative of the information already provided to, and vetted by, CMS.

Alternative Request for Waiver from Rule 5.405(c)2

As an alternative, Vytalize Health 9 requests that GMCB partially waive the requirements of Rule 5.405(c)2 in order to diminish the unnecessary hardship of re-packaging and submitting information that we have already provided to the Medicare program that has allowed CMS to determine we are approved as a REACH model participant. Specifically, we request that GMCB, in advance of the budget submission, advise Vytalize Health 9 of that information GMCB deems appropriate for the proper and non-duplicative evaluation of Vytalize Health 9 with respect to the size and scope of our ACO as it relates to its impact within Vermont. We are simply requesting that rather being required to respond to every factor described in 18 V.S.A. §9382, subdivision (1) of subsection b, the GMBC**, in advance of budget submission**, advise Vytalize Health 9 for which factors, if any, they require reasonably related information.

Given that Vytalize Health 9 is contemplating less than 2000 Vermont beneficiary lives within its ACO that represents approximately 1% of its total volume, it is simply not reasonable to require the submission of all factors within subdivision (1) of subsection b noted above and good cause therefore exists for a partial waiver that precludes Vytalize Health 9 from having to address all factors requested in its budget submission. GMCB, in requiring all factors within subdivision (1) of subsection b noted above be addressed, in advance of its submission, having already been advised of Vytalize Health's approval by CMS as a REACH ACO and, more pertinently, Vytalize Health 9's size and scope relating to Vermont, presents an unnecessary hardship to Vytalize Health 9 thus necessitating GMCB take action to alleviate this administrative burden and hardship.

Request of Confidentiality

Pursuant to GMCB Rule 5.106, Vytalize Health requests that the GMCB hold in confidence the information contained in this letter and any additional information submitted by Vytalize Health 9 in

support of the waiver request as this information may contain or describe non-public financial information for the company, company trade secrets, and other proprietary information.

Deadline Extension

Vytalize Health 9 has been in regular contact with members of the GMCB staff with respect to the requirements and interpretations relating to the budget submission requirements for Medicare Only ACOs in Vermont. Two (2) requirements for submission are the notification and approval of the budget submission by the Finance Committee of the Board of Vytalize Health 9 as well as the notification and approval of the same by the Board of Managers of Vytalize Health 9 found within the VERIFICATION ON OATH OR AFFIRMATION documents. Given the request for waiver and the need for board approval of the submission, as well as notification provided by GMCB that it is unlikely that our waiver request would be reviewed prior to the October 2, 2023, deadline, Vytalize Health 9 would be unable to have the board review any materials in a timely manner. Our board meets four (4) times annually, with the last meeting having taken place on July 18, 2023, and the next and last meeting of the year to take place on October 17, 2023. We therefore request that GMCB extend the deadline for budget submission a minimum of 45 days from our receipt of GMCB's waiver determination to allow Vytalize Health 9 to complete the budget submission process as requested.

Conclusion

For the reasons described above, Vytalize Health 9 requests that the GMCB waive Rule 5.404(a) and Rule 5.405(c)2 given Vytalize Health 9's participation in ACO REACH, it's limited number of Vermont beneficiaries, and the GMCB's discretion to prevent unnecessary hardship on Vytalize Health 9's decision to provide ACO services within Vermont. Alternatively, Vytalize Health 9 asks the GMCB to accept the partial waiver as set forth within this document. Further, should GMCB determine that Vytalize Health 9 is required to file a budget submission in any form, Vytalize Health 9 respectfully requests a minimum 45-day extension from the date of receipt of the GMCB waiver determination to file the necessary budget submission.

We appreciate your time and consideration of this request and stand ready to provide any additional information you may find helpful in reviewing this request.

Regards,

Gary Thompson

Gary Thompson
Chief Business Officer
Chair, Vytalize Health 9 ACO, LLC, Board of Managers

cc: Office of the Health Care Advocate (via email)