GMCB Hearing on the AHEAD Model
Public Comment - Julie Wasserman
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The AHEAD model is not a good fit for Vermont. AHEAD does *not* address our most pressing problems, and it will distract us from doing so. All the while, our system continues to crumble.

AHEAD does not address:

- Affordability
- Access to care
- Wait times
- The severe shortage of Primary Care Physicians
  Our Primary Care Physicians are declining in numbers, burned out, and rapidly aging. One-third of our primary care physicians are *over 60 years old*. (See the Health Department's latest Physician Census - p4.)
- And yet, AHEAD does not address recruitment or retention of primary care physicians, nor other practitioners in short supply.
- AHEAD does not address the recent loss of an FQHC, nor the precarious stability of other FQHCs.
- AHEAD does allow for additional Medicare payments to primary care providers; however, it provides no such relief to Pediatric practices or practices which primarily serve Medicaid and commercially insured individuals. These additional payments will not cover one-third of Vermont's Medicare beneficiaries who participate in commercial Medicare Advantage Plans. Also, these additional payments are not available to primary care physicians employed by hospitals who choose not to participate in AHEAD.

We must ask, "*How valuable are AHEAD's "Primary Care Investment" Medicare payments if there is a dwindling supply of primary care physicians to take advantage of them, and the payments only apply to a minority of Vermonters? Regardless, these "Investments" will largely benefit hospitals since hospitals own the majority of Vermont's primary care practices.*

- Vermont is negotiating for additional Medicare funding. Will this money also primarily benefit the hospitals? When will we stop pouring money into the hospitals, especially with no guarantee that commercial prices will fall.
- AHEAD does not address our severe shortage of community mental health services and substance use programs. Or insufficient home health care.
- We need to first develop a robust community-based system centered around primary care if we want to curtail unnecessary hospital spending which is the intent of AHEAD. Robust community-based services need to exist *prior to* AHEAD and global budgets.

AHEAD's Total Cost of Care caps will not improve affordability because there is no direct connection between these caps and lower health insurance premiums, co-pays, and deductibles. The former in no way ensures the latter.

The above lists the things AHEAD does not do. Here are some things it does do:

- AHEAD mistakenly focuses on "over-utilization" when Vermont faces an under-utilization problem due to lack of access and high costs.
- AHEAD embeds our failed ACO, OneCare.
- OneCare's involvement in AHEAD *doubles* spending on administrative functions.
- The AHEAD model is administratively complex and imposes considerable administrative burdens and costs on both the state and participating entities.
- AHEAD requires "routine adjustments" for upwards of 20 convoluted domains making this initiative onerous and "mind-boggling".
- The AHEAD model promises to increase fragmentation in Vermont's health care system if not all hospitals, insurers, and providers participate. Multiple "payer-specific" hospital budget caps (one for Medicare, one for Medicaid, and a delayed cap for Commercial) encourage a disjointed, non-aligned and complicated approach to controlling hospital costs.
- In terms of participation, more than half of Vermont's hospitals are Critical Access Hospitals who may not want to participate since they will lose their cost-based Medicare reimbursement under AHEAD.
- AHEAD excludes one-third of Vermont's Medicare beneficiaries since they are covered by Medicare Advantage Plans, resulting in a potentially low number of Traditional Medicare participants being served by this model.
- Additionally, there are a high number of Vermonters who are self-insured and would also be outside the model. Almost a quarter of Vermonters are in Self-Funded Employer Plans.
- AHEAD's global budgets "lock in" historically high hospital costs, high prices, extraneous costs, avoidable hospital care, and unnecessary ER utilization because AHEAD uses current and historical hospital spending as the baseline.
- High hospital costs are the result of high "prices". If we hope to address rising hospital costs, we need to standardize prices *prior to* the development of hospital global budgets.
- AHEAD's spending caps could actually *reduce access*. One example is that caps disincentivize hospitals (who own the majority of primary care practices) from expanding needed primary care services since costs will rise due to pent up demand for primary care.
- For people with costly illnesses, AHEAD's hospital budget caps could undermine their delivery of services.

- Please recall that not a single person or provider organization endorsed AHEAD at the GMCB Provider Roundtable in May. Instead, providers voiced concerns about its complexity and "cognitive overload" resulting from AHEAD's different budgets for different payers commencing at different times, using words like "cumbersome", "divisive", "disruptive", "increased administrative burdens". Others cautioned that AHEAD could make health care less affordable and harder to access.
- One of the most serious concerns is that the AHEAD model could inadvertently undermine GMCB's regulatory authority.

It is inconceivable that Vermont would commit to a 9-year untested initiative without a more thorough analysis of AHEAD's cost and effect on Vermont. The outcomes are unknown, and the potential for unintended consequences is substantial.

The AHEAD model ignores Vermont's most urgent problems and will consume precious time and resources better spent addressing our current challenges.

We need to explore alternatives to AHEAD that address our most pressing problems.