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TO: Green Mountain Care Board, Vermont Agency of Human Services, and Governor Scott

RE: Critique of the AHEAD Model

FROM: Julie Wasserman, MPH

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Vermont's health care reform efforts have the best intentions but often fall short of meeting their goals. The All Payer ACO Model stands as an example, along with its potential successor, the CMS sponsored AHEAD model. To avoid repeating past mistakes, we need to determine whether the AHEAD model will confront Vermont's most critical challenges. Early signs point to the fact that it will not address affordability, primary care shortages, access to care, hospital prices, fragmentation, or administrative costs; and may worsen some. Vermont should forgo AHEAD.

The AHEAD model proposes "Statewide Accountability Targets" on Total Cost of Care, Primary Care Investments, and Equity and Population Health Outcomes. This model would begin in 2026 and extend for 9 years. The Agency of Human Services plans to submit its AHEAD application (non-binding) in anticipation of the upcoming March 18th deadline. CMS will provide a "Notice of Award" in May. The critical question is whether the AHEAD model will benefit Vermonters. Will it solve Vermont's most fundamental problems:

- Affordability
- Insufficient primary care
- Access

Affordability

Affordability is the most pressing concern for Vermonters. Costly premiums, co-pays, and deductibles vex employers, hobble school budgets, and deter people from seeking care. Vermont needs specific targeted initiatives to make health care more affordable. Ironically, the Agency of Human Services' 47-page Powerpoint presentation on the AHEAD model to the Green Mountain Care Board makes no mention of affordability. In fact, the word "affordability" is nowhere to be found.

Stunning proof of the high cost of health insurance is illustrated by Vermont's cumulative average *insurance rate increases* for Qualified Health Plans, measured against the base year of 2018 (p.32):

	MVP Individual	MVP Small Group	BCBS Individual	BCBS Small Group
2024	80.4%	60.2%	64.6%	46.2%

Total Cost of Care (TCOC) is foundational to the AHEAD model and is the primary driver of this initiative to control cost growth. Unfortunately, TCOC does not address affordability or access, the two most significant problems facing Vermonters. Total Cost of Care caps will not improve affordability because there is no direct connection between Total Cost of Care caps and lower health insurance premiums, co-pays, and deductibles. The former in no way ensures the latter.

AHEAD's Total Cost of Care targets will be implemented through payer-specific hospital budget caps**:** a Medicare hospital global budget, and a Medicaid hospital global budget. Squeezing the public payers through such caps often comes at the expense of rising Commercial rates to offset losses. Since we have no assurance that Vermont's dominant insurer, BCBSVT, will participate in the AHEAD model, affordability could worsen in the model if costs are shifted to the commercial sector. Additionally, AHEAD's hospital global budgets exclude co-pays and coinsurance (p.44). Out-of-pocket costs comprise 12% of Vermont health care spending (p.23) and are a major determinant of affordability. Adherence to AHEAD's mandated budget caps may result in shifting costs to co-pays and coinsurance which remain outside the cap, leading to higher out-of-pocket costs.

Moreover, TCOC hospital caps could curtail access since Vermont hospitals own the majority of primary care practices in the state. *In no way do we want to limit or cap primary care utilization or growth.* Given the pent-up demand, Vermont desperately needs reliable and proven initiatives that *increase* access to primary care.

Insufficient primary care

Primary care is the fundamental underpinning of a highly functional and cost-effective health care system. Robust primary care increases access to care, improves health outcomes, and reduces costs. However, Vermonters are unable to secure a primary care physician, primary care practices are booked and not accepting new patients, and some practices are struggling to survive. Vermont's primary care crisis is dire.

The Vermont Department of Health's recently published 2020 Physician Census (latest available data) confirms this dire assessment. These data paint a grim picture of Vermont's primary care physician workforce whose situation has only worsened since this information was collected.

- During the period 2000 to 2020, the total number of physicians has grown almost 80% (1480 to 2633), with growth occurring in specialty care at the expense of primary care.
- Over this 20-year period, the number of primary care physicians has declined (585 to 566) while the number of specialists has more than doubled (895 to 2067).
- In 2020, 33% of primary care physicians were over age 60, as compared with only 9% in 2002.
- Between 2010 and 2020, primary care FTEs in Vermont declined by 65.8 (13%) while specialist FTEs increased by 130.5 (15%).
- The statewide ratio of primary care physician FTEs to population *decreased* between 2018 and 2020.

The AHEAD model does nothing to address Vermont's primary care crisis. Recruitment and retention initiatives for primary care physicians are absent. Vermont needs to grow, attract, and retain primary care physicians using a variety of approaches, none of which are included in the AHEAD model. Vermont needs to:

- Develop and implement a statewide plan to strengthen and fortify primary care.
- Conduct a recruitment campaign to bring primary care physicians to Vermont.
- Implement systemwide loan repayment and debt reduction for primary care physicians who commit to practice in Vermont.
- Increase the number of Family Medicine Residency spots at UVM Medical Center.
- Establish new rural Family Medicine Residency Training sites.
- Narrow the pay gap between specialists and primary care physicians.
- Incentivize hospitals, who own the majority of primary practices in Vermont, to expand primary care services (via the Hospital Budget Guidance or other means).
- Reduce administrative burdens borne by primary care physicians.
- Minimize quality measures, data collection requirements, and prior authorization.
- Develop a supplemental payment program for Independent primary care practices.

Some may argue that AHEAD's "Primary Care Investments" will help strengthen the delivery of primary care. The initiative provides an extra $17 Medicare payment (per patient per month) for primary care physicians. This CMS bonus payment applies to Traditional Medicare beneficiaries and appears to exclude Medicare Advantage enrollees who now comprise nearly one-third of all Vermont Medicare eligible beneficiaries. Furthermore, a majority of Vermonters are missing from this "Primary Care Investment" initiative because they are commercially insured.

How valuable is AHEAD's "Primary Care Investment" Medicare payment if there are too few primary care physicians to take advantage of it, and the payment only applies to a minority of Vermonters? Regardless, these "Investments" will largely benefit hospitals since they own the majority of Vermont's primary care practices.

Access

Vermonters have difficulty accessing health care services due to cost, an inadequate supply of primary care physicians (both described above), and long wait times (described below). AHEAD does nothing to address long wait times and may exacerbate the problem through its hospital global budget caps.

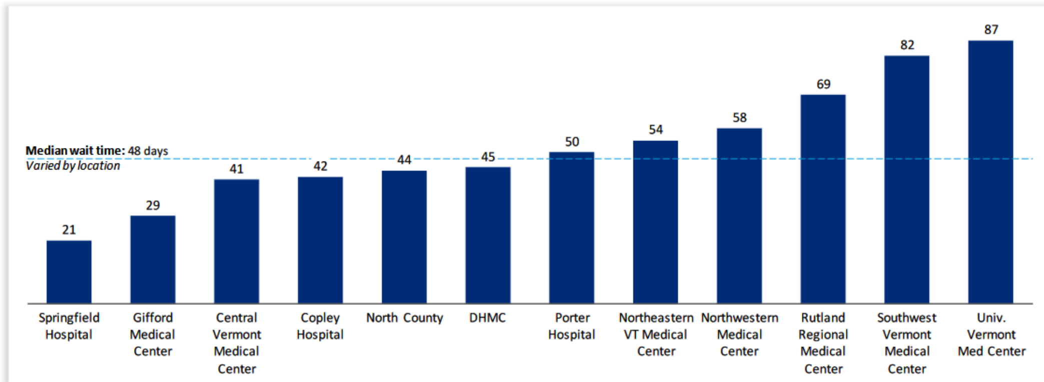
Delayed care can lead to pain (both physical and psychological), increasingly severe illness, and financial hardship due to costs associated with advancement of the disease. "The risk of patient mortality significantly increased when wait times were longer than 31 days among older and more vulnerable patients." (p.7)

Wait times are a long-standing problem in Vermont and predate the COVID pandemic. During the period 2017 through 2019, the Oliver Wyman Report found the average number of days between a Primary Care Physician visit and a follow-up Specialist visit was approximately 100 days (p.23). More current data from 2022 show median wait times for Specialist visits - see graph below. Note the comparison of Dartmouth

Hitchcock to UVMMC, both tertiary medical centers. UVMMC's wait times are almost twice Dartmouth's. Slide 8.

Access:
WAIT TIMES

Secret Shopper: Wait times for specialist appointment by site
Median wait times in days



Note: hospitals offer different mix of specialties and some offer more of the specialties with longer wait times
Source: State of Vermont Wait Times Report, 2022

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Arbitrary Hospital Prices

Hospitals drive cost growth and many experts agree that the *price* of health care services is the chief contributor. In other words, excessive costs are the result of high prices, not high volume. (Uwe Reinhart, Anderson, et.al., Whaley, et.al., Papanicolas, et.al., Cooper, et.al., Sage Transparency, Gusmano, et.al., Michael Bailit, Robin Lunge-GMCB slide 7, and others.) This point is lost on the AHEAD model which assumes Fee-for-Service and volume are the problem. However, it is apparent that over-utilization (volume) is not the culprit in Vermont given long wait times to obtain care, workforce shortages which reduce access, lack of access to primary care and subsequent referrals, and people's hesitancy to seek care due to cost. If we hope to address rising costs, we need to turn our attention to hospital prices.

Hospital prices have little basis in reality. Commercial charges are set arbitrarily and vary wildly for the exact same service. A prime example of this is obstetric care for a routine newborn delivery which costs $5,385 at one Vermont hospital but only $2,192 at another Vermont hospital (p.23).

A 2022 RAND Corporation report on hospital price transparency for the period 2018-2020 found UVM Medical Center set its commercial prices (inpatient and outpatient combined) at more than 300% of Medicare prices. This means employers and private insurers pay more than three times the relative amount Medicare would pay for the same service. Conversely, Dartmouth Hitchcock Memorial Hospital set its rates at 177% of Medicare prices (nearly half UVM Medical Center's prices).

One approach to standardizing hospital prices is "reference-based pricing" where the price of a given procedure is the same regardless of the provider. The price for a service can be determined by indexing (or referencing) it to a multiple of the Medicare rate since Medicare rates are a well-established national standard, transparent, linked to quality measures, and most importantly, are not subject to bargaining leverage.

Despite the All Payer ACO Model's best efforts, Vermont's health care system continues to be primarily based on fee-for-service payments, making it a suitable match for reference-based pricing. Reference-based pricing is a fee-for-service tool that, once implemented, lays the groundwork for rational hospital global budgets. This kind of standardization needs to occur *prior to* developing hospital global budgets.

Under the AHEAD model, arbitrary prices, extraneous costs, avoidable hospital care, and unnecessary ER utilization get "baked in" to hospital global budgets because AHEAD uses current and historical hospital spending as the baseline. This is an illogical approach. A case in point: ER utilization comprises *almost two-thirds* of Vermont's acute care hospital volume. (Statewide average: 65%, UVMMC: 64%, Rutland: 77%, Bennington: 77% - slide 10.) Since UVMMC accounts for roughly half of the state's hospital expenditures, ER utilization of this magnitude represents costly spending and offers *an opportunity for significant savings if avoidable care were provided in lower cost community settings*. Given the right incentives, a substantial portion of ER care could be performed in lower cost community settings or avoided all together. The Green Mountain Care Board (GMCB) could utilize its Hospital Budget Guidance to incentivize hospitals to collaborate with local primary care practices, community mental health centers, and home health to reduce unnecessary and avoidable ER utilization.

The State Auditor of Accounts found that Vermont could potentially save $16.3M annually if it implemented reference-based pricing for state employees. Montana employed this approach and saved $47.8 million from FY 2017 to FY 2019. These savings were used to improve affordability as Montana state employees saw no increase in premiums, out-of-pocket costs, or reductions in benefit plan for six consecutive years.

Vermont's rate-setting language contained in Act 48 (p.30-31) could be used to implement referenced-based pricing which is a form of rate-setting. This method of rate-setting not only addresses price differentials among payers but can also be utilized to strengthen underserved areas of Vermont and primary care shortages. Even though the GMCB currently has no direct purview over primary care, this is an avenue to pursue given Vermont's statutory language:

> "*In establishing rates, the board may consider legitimate differences in costs among health care professionals, such as the cost of providing a specific necessary service or services that may not be available elsewhere in the state, and the need for health care professionals in particular areas of the state, particularly in underserved geographic or practice shortage areas.*"

Lastly, fee-for-service is not the villain it is purported to be. Many high-income countries employ fee-for-service, yet they spend less per capita than the U.S. and have better outcomes. Incidentally, fee-for-service works best for services that are in short supply because it incentivizes greater provision of needed services. Examples include primary care, mental health counseling, and substance use disorder services. AHEAD provides no direct service funding for the latter two, and its capped budgets could inadvertently curtail these critical and inadequately funded services.

Critical Mass
A critical mass is necessary for AHEAD's success. Current predictions assume Vermont's Traditional Medicare and Medicaid enrollees will participate in the model. However, the majority of Vermonters are commercially insured (p.6), and there is no guarantee commercial insurers will participate. CMS requires that only one Vermont hospital "sign on" with a non-binding letter of intent. A detailed hospital recruitment plan is required but such a plan could easily prove hollow and unrealized. Once the model begins, any hospital can drop out at any time. Only one insurance company is required to participate in the AHEAD model and not until 2027. Moreover, non-hospital owned practices are excluded from the global budget caps and not subject to the initiative's mandates, as is the case for Medicare Advantage.

Fragmentation
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 each for Medicare, Medicaid, and a delayed Commercial) encourage a disjointed, non-aligned and complicated approach to controlling hospital costs as does CMS's irresolute phase-in of its Medicare caps. In the first year of the AHEAD model, only 10% of Traditional Medicare spending is capped, growing to a mere 30% by year four. This kind of incrementalism can easily become unmoored.

The AHEAD model shifts regulation of hospital budgets to the Agency of Human Services (AHS) via its Total Cost of Care targets for hospital global budgets. This circumvents the current regulatory authority of the GMCB whose enabling statute requires it to be an independent body immune to the political pressures of the Executive branch. Having AHS oversee hospital budgets politicizes the process since AHS serves at the pleasure of the Governor. Additionally, having AHS regulate hospital budgets presents a major conflict of interest. AHS Medicaid is a payer and a payer cannot be a regulator. AHEAD paves the way for the AHS Director of Health Care Reform to perform regulatory duties in isolation of open meetings and public input. In other words, there would be less transparency and due process, both of which are signature components of the GMCB. Furthermore, the GMCB recently developed and implemented a valuable tool to oversee hospital budgets: the Hospital Budget Review Tool utilizes an expense-based approach for evidence-based oversight of hospital performance.

Administrative Cost
The AHEAD model imposes considerable administrative burdens on both the state and participating entities resulting in a costly and potentially onerous program. Requirements include routine "adjustments" for the following domains: Baseline Incentives, Social Risk Adjustments, Global Budgets and Payments Adjustments, Inflation Adjustments, Beneficiary Adjustments, Policy Adjustments, Performance Adjustments, Service Line Changes, Market Shifts, Tertiary Care Adjustments, Critical Access Hospital Adjustments (more than half of Vermont's hospitals are CAHs and will lose their cost-based Medicare reimbursement), Quality Adjustments, Health Equity Adjustments, Effectiveness Adjustments, Downward Adjustments for potentially avoidable utilization, and Downward Adjustments for Overuse (e.g. Prostate cancer testing for men 75+, Cervical cancer screening for women 65+) p.51-71.

CMS is offering Vermont "up to $12M" in Federal support funds dispersed at $2M per year which will barely cover the administrative costs of this cumbersome initiative. CMS mistakenly earmarks these funds for administrative functions instead of supporting the providers for whom this "transformation" is intended.

Will the AHEAD model constrain the practice of medicine through its myriad financial requirements, e.g. prescriptive "adjustments"? Will the AHEAD model restrict the provision of medical services guaranteed by benefit plans? Will the AHEAD model undermine the delivery of services, both inpatient and outpatient, for people with serious illnesses requiring costly care? As the recent New England Journal of Medicine article on AHEAD states, "*Under global budgets, health systems can benefit financially from withholding expensive services from patients who need them.*"

Conclusion

The AHEAD model is administratively complex and costly. It splinters regulatory authorities and carries multiple unknown and unintended consequences. The model ignores Vermont's most urgent problems and will consume precious time and resources better spent addressing the aforementioned concerns.

In summary, Vermont should:

- Forgo the AHEAD model given the huge discrepancy between what Vermont needs and what AHEAD offers.
- Pursue initiatives that directly improve affordability, access to primary care, and wait times for all Vermonters.
- Strengthen and fortify primary care.
- Implement reference-based pricing *prior to* developing hospital global budgets.
- Explore strategies for site-neutral billing to address payment differentials that favor hospital-owned outpatient services.
- Prevent the parsing of health care system responsibilities among various state entities, especially those subject to the influence of the Executive branch.
- Preserve and enhance GMCB's employment of its valuable Hospital Budget Review Tool.
- Utilize Vermont's currently existing regulatory authorities and statutory constructs to accomplish recommendations in this critique.
- Strengthen and fortify the GMCB through additional Legislative funding.