Julie Wasserman, MPH
Health Policy

TO: Green Mountain Care Board

RE: Comments on the AHEAD Model Term Sheet

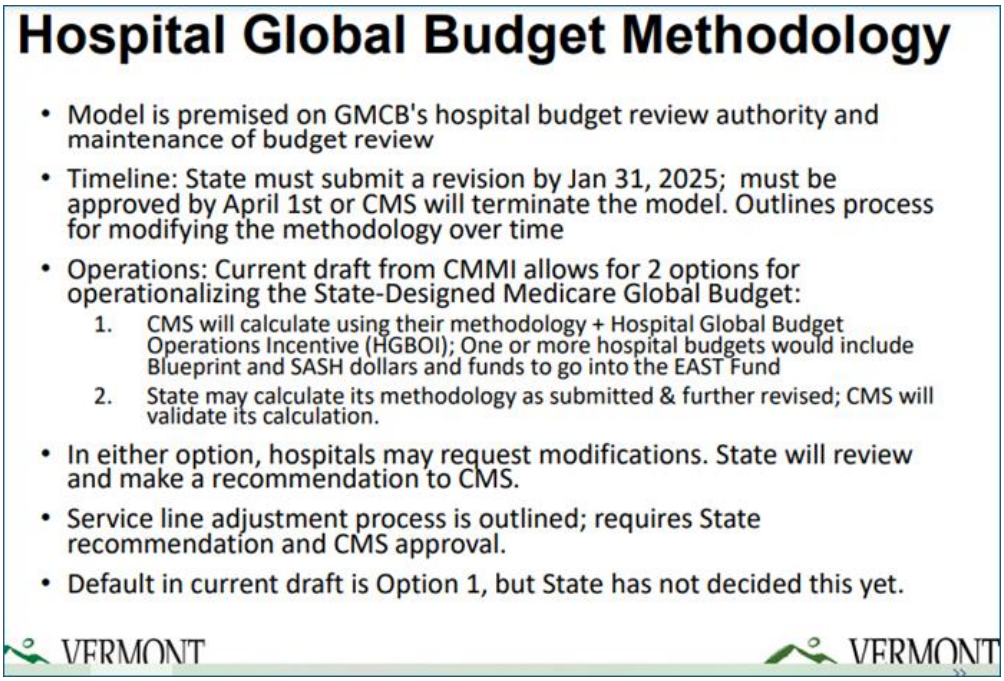
FROM: Julie Wasserman, MPH

DATE: December 23, 2024

The Green Mountain Care Board has requested public input on the AHEAD Model Term Sheet. The following comments document ongoing concerns and recommendations.

Green Mountain Care Board's Authority to Regulate Hospital Budgets

The December 18, 2024 Agency of Human Services (AHS) ppt presentation to the GMCB on AHEAD includes the slide below (#21). This slide states that in operationalizing the Medicare Global Budget, "*hospitals may request modifications. State will review and make a recommendation to CMS"* (4th bullet). This language appears to grant the State-AHS and CMS final authority over hospital budget decisions. If so, this provision would undermine the GMCB's regulatory authority in establishing *final* hospital budget orders, an authority enshrined in Vermont statute.



Furthermore, AHS serves at the pleasure of the Governor, and CMS/CMMI serve at the pleasure of the federal administration. In other words, the entities ultimately responsible for finalizing hospital budgets would be vulnerable to political pressure, resulting in an erosion of transparency and accountability.

Global Budgets

AHEAD's hospital global budgets are intended to incentivize the reduction of a) potentially avoidable hospital care, b) low value hospital care, and c) unnecessary readmissions. However, hospital global budgets are a blunt instrument and may not have the desired effect; global budgets in and of themselves are not sufficiently precise to achieve these goals.

The potential for unintended consequences from AHEAD's global budgets could further degrade access. Under a cap, hospitals may feel forced to provide less care and reduce capacity. As Member Murman described, a reduction in inpatient beds can lead to increased ED boarding as evidenced in Maryland and pose safety issues. To compound matters, AHEAD would hold Vermont harmless for out-of-state expenditures, further incentivizing a reduction in available hospital services. To meet the caps, patients could be sent to upstate New York or New Hampshire hospitals.

The TCOC Performance Adjustment, with its ill-fated 2-year lag, "protects against shifting hospital costs to community providers". This siloed approach is the opposite of what is needed. Vermont should pursue initiatives that induce hospitals to integrate with their community providers, moving low value and avoidable care out of hospitals and into the community. This is especially the case for ER over-utilization.

Blueprint and SASH

Vermont needs to untether Blueprint and SASH from its health care reform initiatives. These well-established long-serving programs have reliably contributed to improved outcomes and should not be dependent on the latest reform model or the political whims of a new administration. Stable funding would secure their survival.

Alternative funding sources need to be considered. Ten million dollars is a small amount to procure and need not play a major role in determining whether Vermont participates in the AHEAD model. The hospitals currently supply this $10 million to support both Blueprint and SASH. Since hospital revenues are fungible, could the hospitals continue contributing under a different framework? DVHA's Hospital Global Payment Program (GPP) provides a suitable vehicle to accomplish this. (This might offer the added benefit of federal match.)

Would Medicaid and Commercial payers consider enhancing their current contributions? Funds could be transitioned given the sunsetting of initiatives such as Comprehensive Payment Reform (CPR) and other programs.

Regarding Medicaid enhancements, Global Commitment funds are federally matched which reduces the General Fund obligation. As Member Lunge confirmed at a recent GMCB meeting, "Typically, our Global Commitment 'cap' has been quite generous", which would allow for additional Medicaid funding of the Blueprint program. Lastly, the AHS Department of Disabilities, Aging and Independent Living funded SASH in the past; could they contribute to SASH going forward?

If each of the entities above contributed a portion of the $10 million, financial impacts on any given party would be minimal.

Participation of Medicare Enrollees in AHEAD

The number of Medicare enrollees served by AHEAD will likely be fewer than those served in Vermont's All Payer ACO Model, which translates into lower Medicare FFS hospital NPR percentages. With *all* hospitals participating, the APM served only 48,303 Medicare beneficiaries at its height in 2019 (p.6). Moreover, when we met with CMMI Director Liz Fowler in the Spring to share our concerns about the model, she pointedly stated, "It can't be just one hospital".

Almost one-third of the state's Medicare beneficiaries are excluded from AHEAD because they are enrolled in Medicare Advantage (MA) Plans. As MA penetration grows, AHEAD's investment dollars shrink. Will it be cost effective for Vermont to pursue AHEAD given the potentially low number of Medicare participants to be served? Medicare Global Budgets covering so few Medicare enrollees are in no way "global".

Affordability and Access

The patient portion of hospital payments is a significant source of revenue for hospitals. However, it is excluded from AHEAD's hospital global budgets. Adherence to AHEAD's mandated budget caps may result in shifting costs to co-pays and coinsurance which remain outside the caps. This will lead to higher out-of-pocket costs which comprised 12% of Vermont health care spending in 2020 (p.23) and have likely grown. Out-of-pocket costs are a major determinant of affordability and a significant deterrent to seeking care; higher costs will lead to further declines in access.

General Themes

Vermont's dominant commercial insurer, Blue Cross/Blue Shield, is struggling to remain solvent. How realistic is it to assume it could successfully participate in AHEAD's capped commercial budgets? Mandatory participation is not the answer because it could further compromise both the organization itself and the model.

The AHEAD model will dramatically increase both administrative costs and fragmentation of the system since not all hospitals, providers, or payers will participate.

AHEAD does not address skyrocketing commercial premiums, high prices, the instability of our Critical Access Hospitals and FQHCs, and our fragile community-based system.

As one of the lowest-cost Medicare states in the nation, why would Vermont want to participate in a model whose goal is to reduce Federal spending?

Readiness: Our faltering community-based system is ill-equipped for AHEAD. 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. Vigorous community-based services need to exist *prior to* AHEAD and global budgets.

At a May 2024 GMCB Panel Discussion on hospital global budgets, only one of the five national experts carefully selected to discuss the benefits of global budgeting supported Vermont's AHEAD model. Another panelist abstained. Yet, three of the national experts admitted in response to specific questions that AHEAD was not a good fit for Vermont.