# Memorandum

To: Liz Fowler, Christina Crider, Kate Sapra, Amanda Johnson, and Arrah Tabe-Bedward

RE: Provider Roundtable Testimony on Vermont's AHEAD Model: GMCB, May 15, 2024

From: Mark Hage, Julie Wasserman, and Patrick Flood

Date: May 30, 2024

Dear Director Fowler and CMMI Staff:

Since we and other colleagues met with you, we have engaged with the Green Mountain Care Board (GMCB) on the AHEAD model and shared our opposition to it. Our objections, as you know, are anchored to the conviction that AHEAD will not make it possible for Vermont to overcome the lack of affordable and timely access to primary care, mental health, home health, nursing services, and community care generally. Nor provide the structural means to substantially lower the costs of health care services and health insurance. We are not alone, as what follows makes clear.

On May 15, GMCB held a "Provider Roundtable" on the AHEAD model. Major stakeholders voiced a range of concerns about AHEAD, and many directly questioned its viability as an effective reform model for Vermont. A transcript of these testimonies is not available, but a video recording of the Provider Roundtable is:

(1) https://www.youtube.com/watch?v=nSYaAwFEZX0&ab_channel=GreenMountainCareBoard, beginning at 1 hour, 8 minutes, 40 seconds, and continuing here:
(2) https://www.youtube.com/watch?v=KrlyBOZHgjQ&ab_channel=CNA.

The first four pages in this narrative offer our summary of prominent themes and issues that stood out for us on May 15 (presented in the order each person testified), and, which, among other things, demonstrate provider opposition to or, minimally, a lack of consensus on AHEAD; apprehension with the pace of Vermont's engagement with the model; and support for investigating alternative options that are truly systemwide and grounded to trusted data. You will find our notes on the Provider Roundtable on pages 5-14.

**Lack of Commitment to AHEAD**

Admittedly, we are partisan observers. Just the same, we were struck by the fact that not a single person or provider organization at the Provider Roundtable endorsed AHEAD, including those who spoke for hospitals:

- **Rick Vincent**, the Chief Financial Officer of the University of Vermont Health Network, noted that the Network's letter of interest to participate in AHEAD was non-binding. Like others who testified, he acknowledged there is much that is still unknown about AHEAD.

- **Joe Woodin**, Chief Executive Officer of Copley Hospital, saw "a lot of red flags" and could not see how AHEAD would help Critical Access Hospitals, the great majority of Vermont's hospitals. In his estimation, Vermont is at risk of traveling the same road as it did with OneCare Vermont, and that journey did not accomplish what it intended despite its high cost. Vermont, he opined, would conceivably be better served by not trying to "lead" at this time with AHEAD, but by following its own path.

- **Judi Fox**, Chief Executive Officer of Rutland Regional Hospital, explained that her hospital signed a "letter of interest" in AHEAD in the hope it would increase Medicare funding for hospitals and the rest of the health care system, which, in turn, would help mitigate commercial premium increases. She expressed concern that the "AHEAD model does not provide a pathway for improved access to hospital care, specialty care and primary care." Ms. Fox warned, too, that models like AHEAD can be "cumbersome [and] divisive." She stressed that hospitals and clinical practices in local communities need expanded resources and infrastructure to provide mental health, primary care, home health, post-acute care, EMS, and long-term care services; the lack of such resources and infrastructure means hospitals will be compelled to continue to provide care that the AHEAD model deems "avoidable." On any given day, 10% of the hospital beds at Rutland Regional are filled with people who should be in another setting, a problem not unique to her hospital by any means. Her institution, therefore, is "very concerned" with the definition of and requirements related to the definition of "potentially avoidable care" in the context of a health care system that does not have sufficient infrastructure and personnel to provide non-acute medical care.

- **Devon Green**, Vice President of Government Relations, for the Vermont Association of Hospitals and Health Care Systems, said her group was open to "exploring" the potential for progress with AHEAD, but acknowledged there is "A lot of concern about the disruption it could cause, …." Echoing prior speakers, she concurred that "we have no room for error." Though most of her commentary was about global budgets, she asserted that Vermont needs to decide on what terms it would be prepared to "walk away" from AHEAD. At present, those terms are far from clear, and their absence could create a future scenario where AHEAD becomes an "unstoppable force." Intended or not, Ms. Green's "unstoppable force" characterization raises the specter of Vermont's unfortunate experience with OneCare Vermont.

**AHEAD'S Complexity & Opacity**

There was sincere respect expressed at the Provider Roundtable for the work of the Agency of Human Services in preparing and explicating the AHEAD application. Despite the considerable effort this has entailed, however, there was near unanimity of opinion on the immense difficulty of understanding how AHEAD is designed to function as a model and its operational details.

- **Joe Woodin** thinks of AHEAD as "beyond rocket science," including for those well versed in the health care system.

- **Rick Dooley**, who practices primary care as a PA, used the word "tremendous" to qualify the complex nature of AHEAD and said providers in his world cannot understand it or how it is going to affect their ability to remain financially viable (especially if the CPR program is phased out).

- **Susan Ridzon**, Executive Director of HealthFirst, an association that represents independent medical practices, considers AHEAD "astonishingly complex" and a project that may prove expensive to operationalize. She added that this kind of structural complexity and its administrative challenges often drive providers (especially primary care physicians) out of health care altogether, into Direct Care models where no commercial insurance is accepted, or into relationships with Private Equity firms. She also asserted correctly that there has been no detailed analysis of AHEAD versus alternative options, and that such an analysis should be conducted before Vermont acts.

- **Mary Kate Mohlman**, Director of Public Policy for the Bi-State Primary Care Association representing Vermont's Federally Qualified Health Centers, described AHEAD as "a three-dimensional jigsaw puzzle with no box cover."

- **Alicia Jacobs**, who has practiced family medicine in Vermont since 1996 and is a national delegate to the American Academy of Family Physicians Commission on Quality and Practice, worries about the "cognitive overload" AHEAD may lead to by virtue of its different systems for different payers.

- **Andrew Garland**, Vice President of External Relations for Blue Cross Blue Shield of Vermont, the largest commercial insurance carrier in the state, reflected on AHEAD potentially making our health care situation even more complicated and adding a huge administrative layer.

- **Trey Dobson**, Emergency Room Physician, said the complexity of AHEAD is "real," then spoke to how much more complex medical practice has become over the last five decades, presumably to improve quality and lower costs. It did neither, only made the practice of medicine more difficult and expensive.

- **Jon Asselin,** CFO, Primary Care Health Partners (a group of physician-owned, independent Primary Care Practices), said he and his colleagues cannot get a clear sense of where the model is headed.

**Greater Fragmentation & Siloing of the Health Care System**

Speakers warned that the objectives of AHEAD will likely be undermined in practice by the fact that:

- Vermont hospitals can opt out of the model (most hospitals have yet to opt in).

- The participation of commercial payers is voluntary.

- Medicare Advantage enrollees are outside the model despite their growing number.

- Pediatric practices will not benefit significantly, if at all, from AHEAD.

- Only an estimated 15% of patients seen by independent practices will fall within the Medicare orbit of AHEAD, and that figure rises to just 30 percent if Medicaid patients are accounted for.

- Independent practices, which are struggling now, would likely experience a net loss in revenue with AHEAD given that enhanced payments are generated in relation to Medicare patients alone.

- There is no "glide path" discernible for medical practices to harmlessly transition away from the current system to AHEAD.

- There is no evidence AHEAD will reduce reporting and other administrative burdens. On the contrary, providers fear that AHEAD will lead to increased administrative burdens.

- AHEAD does not address the staffing and resource shortages in mental health and home health care.

- The self-insured population, which is comprised of a large number of Vermonters, will continue to play by its own rules.

- There has been no detailed analysis of AHEAD versus alternative options to determine if Vermont should move forward with the model.

Respectfully, it is fair to say few at present understand how the state can initiate and sustain uniform system transformation under AHEAD and tackle our most pressing issues when key health care institutions, patients, and payers are exempt or can choose the sideline. In this regard, if Vermont adopts AHEAD, it could be taking a step backwards into a more complex, siloed, and burdensome reality.

Along these lines, **Mike Fisher**, Chief Advocate at the Office of the Health Care Advocate, stated it is important to keep things as simple as possible in confronting our health care problems. There are alternatives now, he said, to make health care more affordable and accessible, and to lower costs: for example, expanding the SASH program. Low-tech, simple, community-based programs like SASH are needed to deliver care and care coordination. If done on a greatly expanded scale, he is confident these approaches would improve care and reduce costs.

**Affordability & Access**

Once more, Vermont's most vexing problems are affordability and access. Yet AHEAD does not address either, and speakers gave persuasive testimony on how the model could make health care less affordable and harder to access. Presenters also urged the state not to lose sight of the worsening crisis in community-based care and spoke to AHEAD's limitations in positioning the state to mount a comprehensive, systemic, and effective response.

Not heeding this counsel to its fullest extent will bring greater loss and hardship to Vermonters, and to our health care system, especially to providers in primary care, mental health, nursing, and home health.

**Conclusion**

The Provider Roundtable on May 15 solidified our opposition to AHEAD for Vermont.

We remain convinced that we must pursue – and are collectively capable of designing and implementing – Vermont-based solutions to the deepening problems of affordability, of timely access to community care, of critical shortages of community care providers, and of declining quality.

Thank you.

# Provider Roundtable on AHEAD

## Main Points & Concerns in Testimony Before the Green Mountain Care Board

## May 15, 2024

**Alicia Jacobs, MD; practicing Family Medicine in Vermont since 1996, American Academy of Family Physicians-VT Chapter Board Member, and National Delegate for the American Academy of Family Physicians Commission on Quality and Practice**

a. Burnout rates statewide for Primary Care Physicians are upwards of 80%. Even though we have the right goals in mind, I'm particularly worried about our fragile workforce and this major disruptive change that's coming with AHEAD.

b. I'm worried that AHEAD will lead to an overall decrease in primary care investments because AHEAD's Medicare primary care investment is not for all payers; just a small segment of our patient population.

c. I'm also worried about the cognitive overload of having different systems for different payers.

d. I'm worried that AHEAD is Medicare-only, and Medicare Advantage gets exempted; I don't like that. I want to treat all my patients the same. I don't want different systems for different populations.

e. I'm worried that this will be a big loss for primary care with the loss of the Comprehensive Payment Reform (CPR) Program.

f. I don't want increased reporting.

g. I'm concerned that certain hospitals can opt out.

h. Regarding the change control, who would manage this and how are we going to support our fragile workforce during this massive change? I've watched PCPs decrease their FTEs because it's harder and harder to do this work. I'm worried that our workforce is contracting and we're not supporting PCPs enough. We need to increase our investment in primary care.

i. Are there other options other than AHEAD? We need to explore all options and all strategies.

**Rick Dooley, Family Practice PA at Thomas Chittenden Health Center for the last 24 years, and Health First Clinical Network Director representing Independent Physician Practices in Vermont**

a. I appreciate Alicia Jacobs' comments. I think she actually read right off my notes because I have every single point she had.

b. Significant concerns include:

- We have a crippling lack of access to primary care.
- We need to reduce the administrative burden in primary care.

- We need an increased ability to recruit and retain primary care providers.
- We need increased flexibility in how care is delivered.
- It's not clear to the provider community how AHEAD will address these access concerns or how it will encourage people to seek primary care.

c. We're concerned about the small number of patients this model will affect.

d. A critical mass of 60%-65% of people is needed in a payment model before you can actually change the way care is delivered. This is a Medicare model so maybe 15% of our patients will be affected.

e. I agree not having Medicare Advantage patients is a huge problem especially since Medicare Advantage patients are an increasing demographic in Vermont, so the number of straight Medicare patients is decreasing over time.

f. Combining Medicare and Medicaid patients is only about 30% of our practice. If the Commercials don't participate, it becomes impossible to make any real transformation.

g. Will enhanced Medicare payments be aligned with enhanced Medicaid payments?

h. Vermont has a huge, self-insured population that plays by their own rules.

i. What happens to the Pediatric practices who serve very low numbers of Medicare patients and will not benefit from Medicare's enhanced payments?

j. Losing the CPR program will be a big loss; capitation in the AHEAD model doesn't begin until maybe 2027. A number of practices will experience a net loss in revenue with AHEAD given enhanced payments occur only with Medicare.

k. The complexity of the AHEAD model is "tremendous". Nobody really understands the model, making it hard to even know what questions to ask. Providers cannot understand the model so it's hard for them to understand how it's going to affect their ability to remain viable.

l. If Independent and Non-hospital practices start closing, the cost of health care will increase. If the AHEAD model destabilizes low-cost care provided in the community, Total Cost of Care will increase.

m. Providers are primarily concerned with the many unknowns in this new system. The AHEAD model seems like we're taking a step backwards to a more fragmented more complex system, and it does not push Vermont in the direction we need to go.

n. Are there other options available that are broader? I'm not convinced AHEAD is the right avenue.

**Susan Ridzon, Executive Director of Health First (an Independent Practice Association representing 131 Primary Care and Specialty Care Physicians practicing in 62 physician-owned Vermont practices.)**

a. There has been no detailed analysis of AHEAD versus other alternative options. An analysis is needed to evaluate whether we should move forward with AHEAD.

b. I don't see a clear glide path for practices to harmlessly transition away from the current system to AHEAD. I'm very worried about this transition destabilizing our already fragile primary care practices.

c. This model does not address affordability. We 've been doing global budgets and Total Cost of Care (via Vermont's All Payer Model) for some time, yet we're still looking at high premium increases of 9-19%. I don't see AHEAD changing that dynamic.

d. The AHEAD model's focus is decreased utilization, which is not an issue in Vermont.

e. Starting in year 4, the enhanced PCP Medicare payments are included in the Total Cost of Care. If we attempt to drive down the Total Cost of Care, it could result in less investment in the primary care system.

f. This model is not a systemwide model and does not address the shortage of mental health or home health services.

g. This model is astonishingly complex and expensive to operationalize. It does not decrease administrative burdens and adds another layer of complexity. It's this kind of complexity that is driving providers out of health care, driving them into the Direct Care model where they don't even accept insurance, or driving them into Private Equity relationships so they don't have to deal with all these complexities. Doctors just want to take care of their patients.

h. This model distracts us from what needs to be done.

i. This model does not make clear who is in charge of Vermont's health care system; is it the Agency of Human Services (AHS) or the Green Mountain Care Board (GMCB)?

j. This model provides no clear evidence that it's going to address Vermont's most pressing problems of affordability and access to care. We should focus our attention on those things we know need to be fixed: providing a glide path for primary care as we move away from the All Payer Model, recruiting and retaining primary care clinicians, strengthening community-based services, increasing access and utilization to lower cost sites of care, and reforming Vermont's Certificate of Need laws which have restricted the establishment of independent facilities and forced most care to be delivered in a more costly hospital setting.

k. Please see Health First's written comments on AHEAD submitted to the GMCB.

**Jessa Barnard, Executive Director of the Vermont Medical Society**

a. The AHEAD governance structure needs clinician representation.

b. Regarding the Primary Care PMPM Medicare enhancement, CMMI's figure of $17 is an average whereas the range is actually $15-$21 and based on statewide performance of variables over

which Primary Care practitioners have absolutely no influence. We would like a more predictable payment and one that is under the influence of Primary Care practices.

c. We are concerned that the enhancement is only for Medicare, leaving out Pediatrics and Medicare Advantage. All practices should be able to benefit from this model.

d. We are also concerned that CMS's Medicare Fee-for-Service fee schedule continues to decrease year over year. This affects Vermont doubly hard because Vermont's Medicaid fee schedule mirrors Medicare's.

e. AHEAD will lead to a disruptive change for primary care, requiring adequate resources and supports for primary care practitioners. Where will those resources live and how will they be funded and supported?

f. We will miss the CPR Program and would like a capitated Medicaid program earlier than planned.

g. We are concerned about the availability of data and the ability to review it and utilize it for attribution, quality, and performance measures.

h. Who is the lead on the Primary Care Spend Target, and how does it relate to our current regulatory structure?

i. We are concerned about hospital sustainability in this model.

j. Please see the Vermont Medical Society, the Vermont Academy of Family Physicians, and the Academy of Pediatrics-Vermont Chapter's written comments on AHEAD submitted to GMCB.

**Judi Fox, CEO Rutland Regional Medical Center**

a. She agreed with much of what was said by presenters before her.

b. Hospitals and community providers need resources and infrastructure (such as in mental health, primary care, home health, substance use disorder care, and skilled nursing facilities) or hospitals will need to continue to provide care that the AHEAD model considers avoidable. On any given day, 10% of the hospital's beds are filled with people who should be in another setting.

c. The AHEAD model does not provide a clear path for how Vermont will solve the problems of access to primary care and even hospital care.

d. Rutland Regional Hospital signed a letter of interest in the hope that the AHEAD model will provide additional Medicare funding for hospitals as well as the rest of the health care system. If Medicare funding increases, it will permit greater investment in closing care gaps, stabilizing hospital funding, and lowering the extent of subsidization of Medicare rates by commercial insurers, thus helping improve affordability for Vermonters. The pursuit of increased funding must be a central part of negotiations with CMMI.

e. Vermont-generated data under AHEAD, as understood now, could be "something at risk and a step back from where we are today." It would be more "siloed" and "not shared from a community perspective."

f. Rutland Regional believes in transformation models, but also understands these models can be "cumbersome, different [and] disruptive at times."

g. While Rutland Regional is "optimistic" with respect to AHEAD's objectives, including its potential to improve health equity, this sentiment is balanced by the concern that the "complexity of [its] payment reform coupled by the need to negotiate for these payment terms and model requirements could challenge Vermont and result in the need to reconsider moving forward."

**Mary Kate Mohlman, Director of Public Policy, Bi-State Primary Care Association representing Vermont's Federally Qualified Health Centers**

a. We all have a lot to learn about the AHEAD model.

b. Federally Qualified Health Centers are struggling right now, some experiencing losses of "seven digits."

c. The services that get cut first are those acknowledged to reduce costs. Cuts in staff hurt access.

d. The details of the AHEAD model matter, including how the Medicare Primary Care PMPM will work. What will happen with the other payers who currently provide enhancements to Primary Care?

e. Having different siloed approaches for care management, care coordination, quality reporting, support services, and data collection is a real burden. Administrative burden is a massive stress on our providers; it is hurting our workforce. How will this be addressed in AHEAD?

f. Vermont needs a strong vision and strong leadership to figure out and manage AHEAD, which she described as "a three-dimensional jigsaw puzzle with no box cover."

**Andrew Garland, VP of Client Relations and External Affairs, Blue Cross Blue Shield of Vermont**

a. Vermont is spending too much money and not serving everyone. Access and affordability remain the biggest problems.

b. We need not be afraid of saying "no" to the AHEAD model.

c. Will AHEAD make our situation more complicated, e.g., global risk sharing.

d. AHEAD will come with a huge administrative layer.

e. Do we have enough evidence that the AHEAD model will address our needs? It seems focused on overutilization, which is not a problem in Vermont.

f. Can we find ways to transition money from the hospital spend to the primary care spend?

g. Remember that most Vermont hospitals have multi-state operations, and for a variety of reasons, a lot of out-of-state people receive care here.

h. Will the AHEAD model pay adequate attention to the shortage of mental health, substance abuse and long-term care services?

i. There isn't much in the AHEAD model that the Green Mountain Care Board could not do itself, other than added Medicare funding.

j. We need to be clear in the beginning about how we will measure success.

**Jon Asselin, COO, CFO Primary Care Health Partners (a group of physician-owned, independent Primary Care Practices)**

a. We are unable to get a clear idea of where this model is headed.

b. We are afraid the CPR program will be disbanded, and we will lose the collaboration among practitioners as well as the additional funding.

c. What will happen to OneCare under AHEAD? (He was passionate about the benefit their practices got from OneCare's CPR program.)

**Joe Woodin, CEO, Copley Hospital**

a. Mr. Woodin reiterated and expounded on points made by several others during the testimony on May 15. For him, "there are a lot of red flags."

b. The AHEAD model is overly complex to understand, even for those in the health care system like himself. There is difficulty even communicating or messaging about it with peers in the system, let alone the general public. *"It is beyond rocket science."*

c. He does not see how this system will be beneficial to the eight **Critical Access Hospitals** in the state. Indeed, it is more likely to introduce more risk for this cohort of institutions.

d. Interestingly, the AHEAD model and what it requires feels like a road already traveled by Vermont with OneCare Vermont, our accountable care organization, which did not accomplish what was intended and at great cost.

e. Why must Vermont see this moment as one of "leading," rather than building on past successes and finding ways outside of AHEAD to continuously improve quality, access, and affordability. Vermont, under the pressure of a CMMI timeline, is looking to take on a leadership role nationally via AHEAD and, in the process, locking itself into a major project with a timeline of nearly a decade. Again, this is risky. Especially when there is much we still don't know about the model.

f. Perhaps it makes more sense for Vermont not to "lead," but to wait and follow what comes that is promising, while also pursuing at the same time Vermont-based solutions to affordability, access, and quality deficits that we know will work, or that have a good chance of working.

g. Finally, while the money offered by AHEAD is attractive, the pursuit of grant money of this kind can distract us from better objectives, and it is often the case that we chase grant money without thinking about what will come when the money runs out. Focusing on the funding can easily distract us from what we need to be doing.

**Rick Vincent, Chief Financial Officer, University of Vermont Health Network**

a. He noted that the UVM Health Network signed a "nonbinding letter of interest" with respect to AHEAD, because there is an "opportunity with AHEAD to at least explore as it potentially aligns with the Network's interests in shifting [the] payment and delivery system in Vermont to be more grounded in value-based care."

b. Three key concerns of a "technical" nature were highlighted. AHEAD must be:

- Financially transparent and actuarially sound, with broad-based oversight of its implementation by a board with representation by hospital administrators, clinicians, GMCB and AHS.

- Structured to "reward" Vermont – not penalize it – for being one of the lowest cost states in the nation when it comes to Medicare spending. What Vermont receives from CMS in money must reflect Vermont-specific trends and access challenges, not regional ones.

- Provide access to good data and the waivers required to act on that data, and without adding to administrative burden.

c. Like others who testified, Mr. Vincent acknowledged that there are a lot of details that are still unknown about AHEAD.

d. Mr. Vincent underscored the potential financial gain that makes AHEAD attractive to his Network: for example, the proposal in AHS's application that the baseline revenue figure for global budgeting in year one of the model be increased by 10%.

- He also commented about historic "underfunding" by public programs like Medicare and Medicaid, and the problem this poses for his hospitals and commercial insurers.

**Devon Green, VP of Government Relations, Vermont Association of Hospitals and Health Systems**

a. Like Mr. Vincent, Ms. Green supports "exploring" the potential for progress with AHEAD. She acknowledged that there is "A lot of concern about the disruption it could cause, and I agree we have no room for error."

- The state, she said at the end of her remarks, needs to determine under what terms it would "walk away" from AHEAD, and to be sensitive to the fact that if we are not clear on when and under what conditions we would walk away from the model, it could become an "unstoppable force."

b. She, like Mr. Vincent, agreed with most of the comments that came before her, but did not elaborate.

c. Most of her time was spent commenting on AHEAD's global budget model. She likes that the AHS application provides more "flexibility" with the global budget methodology than the original CMS proposal, and that it would make possible higher baseline spending for hospitals.

d. She, too, like Mr. Vincent, commented on Vermont being a low-spend Medicare state; our median rate of spending is lower than other states.

e. She accented the importance of "reasonable and adequate rates" for hospitals, and, with an accent on ensuring the "predictability" of hospital revenue, alluded to a future governance and regulatory model that would give hospitals more input into global budget setting.

f. Like Mr. Vincent, she wants revenues and inflationary factors via AHEAD to reflect Vermont-specific factors – transportation issues, long-term care needs, mental health, and our aging workforce were cited.

g. She wants to see more detail on technology, innovation and data gathering, and that care be taken with respect to the fortunes of our critical access hospitals, which "do not have economies of scale."

**Trey Dobson, ER Physician, Dartmouth Hitchcock Medical Center and Southwestern Vermont Medical Center**

a. Dr. Dobson spoke as an ER physician, not as Chief Medical Officer. He, too, agreed with much of what came before.

b. There is a shortage of beds in ERs because of the number of patients who are occupying them because they should be somewhere else, but there is no room for them elsewhere. This exacerbates wait-times for routine ER cases. This problem is much worse today than 15 years ago: 5 to 7 beds occupied on any given day in a 20-bed ER facility.

c. Concerned about hospitals being penalized under AHEAD for avoidable utilization, and with respect to ERs, this issue, as it is presently understood, does not reflect the reality of what is happening in ERs. Most of the patients he sees should be in the ER – at the same time, he understands there is a lack of access to other forms of care outside of the ER. Combined, these factors put hospitals and ER staff in a no-win situation. Plus, where capitation is in force, incentives already exist to send patients to the least costly settings for care. We don't need more penalties in those cases.

d. He reiterated what came up repeatedly: the complexity of AHEAD is REAL, and he spoke to how much more complex medical practice has become over the period of the 1970s through the 1990s, presumably to improve quality and lower costs. But it did not do either, only made the practice of medicine more complex and expensive.

e. Simplifying the practice of medicine, which might initially be more expensive at the front end, will over time lower costs, be easier to reproduce, and make it easier to incentivize staff.

**Michael Fisher, Chief Health Care Advocate, Office of the Health Care Advocate at Vermont Legal Aid**

a. At this time, it would be premature to say whether we should or should not go forward with AHEAD. This can't be known without a more definitive sense of the costs and benefits.

b. The "Deliverable (on AHEAD) must be worth the effort." Millions of dollars have already been spent on consultants and in staff and Board time on this project.

c. Affordability and access are key: Vermonters must see an improvement in both these domains.

d. If we embark with AHEAD, there must be a data collection and analysis model in place to assess success and failure. We are not set up now to do this, and we won't be set up to do this in the future.

e. Keep it simple. There are alternatives now to make care affordable and accessible, and to lower costs: for example, expanding the SASH program. Low-tech, simple, community-based programs like SASH are needed to deliver care and care coordination. If done on a greatly expanded scale, these approaches would improve care and lower costs.

f. As the Scott administration moves forward, there must be an "honest and clear assessment to a majority vote in favor of what comes out of the negotiations [with CMMI] at the end."

g. Why are we in such a rush with AHEAD? Why do we have to be in Cohort 1? Why not take more time to assess the landscape before us? In this respect, he echoed Mr. Woodin's comments about "following" rather than "leading."

h. Vermont must be prepared to "walk away" from AHEAD if it is not right for Vermont.

i. Please see the Health Care Advocate's written comments on AHEAD submitted to the GMCB.

**Vermont Agency of Human Services Health Care Reform Work Group Comprised of Providers**
**Round-up of Themes from the GMCB Provider Roundtable on AHEAD:**

a. AHEAD is very complex and challenging to understand.

b. There are concerns about loss of CPR program for Independent primary care; and ACO support with data sharing, quality measurement, attribution estimates, and financial modeling.

c. There is a need for a "glidepath" between models.

d. Workforce challenges and increases in expenses need to be addressed; they impact access.

e. Vermont should strive towards all-payer, all-hospital, and value-based care models.

f. Adequate clinician involvement in model governance is essential.

g. We need to better understand alternatives and comparisons between options, including the impact on affordability, access to care, and provider stability.

h. Consider “Cons” as well as “Pros” - need to monitor impacts over time to ensure reforms are working for Vermonters.

i. Care delivery and payment reform across the system are essential.

j. Sustaining and expanding access to primary care is critical.

- Continue capitation models, Blueprint, SASH, and Medicare waivers.
- Address concerns that Primary Care AHEAD payments may impact primary care providers differently based on how they are currently paid and their patient mix.
- Administrative burdens must be reduced; there are concerns about Vermont losing the current MIPS reporting exemption.

k. Hospital Global Budgets

- Need to ensure global payment methodology allows for continued investment across the system and increased access to care.
- Providers need access to comprehensive data to be successful.
- We must focus on affordability and access, not overutilization.