COMMENT ON VERMONT INVOLVEMENT IN THE AHEAD PROGRAM

I'm writing in strong opposition to Vermont's involvement in the AHEAD program.

AHEAD is yet another value-based care program created by the Center for Medicare and Medicaid Innovation. Over the 12 years since its creation, this agency has spun out dozens of programs, each of them heavily bureaucratic, but justified under the rubric "Value-based care". That they don't actually provide care, and have little or no value has only occasionally been noted by VBC's proponents. But finally, on the agency's tenth anniversary, a comprehensive evaluation of CMMI's programs was undertaken by the Congressional Budget Office, and they found—unsurprisingly—that rather than saving money and helping to preserve the Medicare Trust Fund, CMMI's programs had actually been losing money for the taxpayers of the US. [i] It has been disturbing that CMS appears to have ignored this report, and the CMMI appears to be plowing ahead with the same ineffective strategy: eliminate the incentives built into the fee-for-service system—no matter how much taxpayer money they have to throw at for-profit subcontractors to lure them into participating, and no matter the magnitude of the administrative cost and headaches it will inflict on providers—especially those practicing primary care. The strategy ignores what every American knows: Excessively high prices are the key problem. That prices-- and not volume of care-- (the only target of CMMI's schemes) constitute at least 90% of excessive costs in the US was laid out in Uwe Reinhardt's 2003 study, [ii] a finding which was confirmed in 2019. [iii]

What is particularly disturbing is that CMMI's analyses use a flawed "benchmarking" system of risk adjustment that the private sector program contractors easily exploit to make their patients appear to have a greater underlying severity of illness (and, consequently, expected expenditures). This benchmarking system, as well as flawed quality assessment measures have both led to excessive payments to the Medicare Advantage program ever since the current system was adopted in 2007. Unfortunately, CMMI adopted this same flawed risk adjustment system to pay the subcontractors who implement CMMI's "value-based care" models. So the evaluations of the CMMI's VBC programs have for that same reason also been biased toward crediting the VBC programs with producing better quality of care and greater financial savings than is actually the case. [iv] [v]

Furthermore, the administrative effort borne by participating providers—hospitals and physician practices-- is generally excluded from estimates of the cost of these programs. And the financial costs are not the only costs that are excluded from CMMI's evaluation efforts: None even attempt to estimate these programs' contribution to primary care practitioners' growing burnout. Given the steady growth of documentation requirements in primary care, the complexity of payments, regulators' demands, and user unfriendly software, the last thing these practitioners need is to have more administrative burdens imposed on them.

In 2021, CMMI announced its intention to (involuntarily) enroll 100% of traditional Medicare beneficiaries into an "accountability relationship" by 2030. [vi] This publication indicates that either enrollment in a Medicare Advantage plan or one of CMMI's value based programs would "count" as an accountability relationship. The AHEAD program is new. Therefore, how administratively

burdensome to providers it turns out to be—especially for primary care practitioners—has yet to be determined. However AHEAD's program guidance indicates that AHEAD will by itself not "count" as an accountability relationship. So beneficiaries in traditional Medicare will simultaneously be obliged to contend with the administrative requirements of the other value based program they will be obliged to contract with , while at the same time complying with the administrative burdens imposed by the AHEAD program.

The AHEAD program's proposed effort to create annual global budgets for hospitals in the context of a complex multipayer system is unlikely to result in cost savings, since it addresses none of the hospitals' cost drivers: It won't reduce the cost of pharmaceuticals or other supplies and equipment, staff compensation, staff recruitment, or contending with payment denials and other administrative burdens imposed by Medicare Advantage plans and other private insurers. The AHEAD program actually adds to an already overwhelming administrative burden.

The one redeeming feature of the AHEAD program is that it proposes to pay primary care practices $17 PMPM for every traditional Medicare beneficiary who received their primary care in participating practices. I estimate this will amount to approximately $100,000 - $110,000 per full time practitioner the first year. This will be quite helpful to independent primary care practices. And to hospital-based primary care practices, it will help to raise the current lowly status of non-procedural practitioners in the eye of hospitals' administrative suites. Noteworthy, however, the proportion of Vermonters yielding to the lure of Medicare Advantage plans' low premiums and intensive advertising will likely result in a continued increase in Medicare Advantage enrollment. This will, in turn, lead to a steady decrease in the amount of money made available to primary care practices through AHEAD, as AHEAD's funding is based on enrollment in traditional Medicare, not Medicare Advantage. And after 3 years, program guidance indicates that these payments to primary care practices come to an end. AHEAD offers little else to boost primary care—neither supporting efforts to increase the number of trainees in primary specialties nor providing more generous and widespread loan forgiveness options. Most disappointingly, far from offering some relief from all the factors that result in primary care practitioner burnout, AHEAD will likely add to practitioner burnout by imposing additional documentation and other administration burdens.

Last year, the Vermont Medical Society (VMS) adopted policies objecting to the involuntary and also the unwitting enrollment of patients into value-based care programs. [vii] As is the case with CMMIs other value-based care programs, it appears that AHEAD participants will be enrolled into the program involuntarily, and in most cases, unwittingly. VMS also objects strongly to reimbursement systems in VBC programs imposing ethical conflicts of interest on their treating clinicians. Given the fact that the major cost control strategies used successfully in other developed countries remain unavailable to physicians and hospitals participating in AHEAD, it is likely that achieving cost control will be difficult. Especially if the AHEAD program elements begin to threaten hospitals' financial stability by their inability to control costs, these hospitals may well transmit financial disincentives to care onto the physicians and other providers participating in the model. This is the exact ethical conflict of interest the VMS objects to in their policy guidance. [viii] Physicians should not be losing money when they order tests or treatments they regard as necessary.

Finally, the AHEAD program requirements entail the elimination of cost-based reimbursement for participating critical access hospitals. This would jeopardize some of the federal funds that eight of Vermont's hospitals depend on to support the treatment of the elderly patients who use their facility. This is unacceptable.

Vermont should forego involvement in AHEAD and instead adopt direct strategies to reduce health costs for Vermonters. One such strategy would be for the state health department to set up a recruitment program for both temporary and permanent positions in all specialties. This could help relieve our hospitals and other providers of the outrageous fees charged by staffing firms. Furthermore, it could be set up to closely coordinate with loan forgiveness programs for primary care, mental health, nursing, and other occupational niches for which Vermont has a significant shortage. In general, Vermont should also do more to promote the training of primary care and mental health providers in Vermont. The minuscule number of training slots in primary care specialties at UVM is disappointing, and deserves prompt attention.

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[i] Congressional Budget Office, Federal Budgetary Effects of the Activities of the Center for Medicare and Medicaid Innovation. September 28, 2023.

[ii] Anderson GF, Reinhardt UE, Hussey P, & Petrosyan V: It's the Prices, Stupid: Why the United States is so different from other Countries. Health Aff (Millwood) 2003 May/June 22(3):89-105.

[iii] Anderson GF, Hussey P, & Petrosyan V: It's Still the Prices, Stupid: And Why the US Spends so much on Health Care, and a Tribute to Uwe Reinhardt. Health Aff (Millwood). 2019 Jan;38(1):87-95. doi: 10.1377/hlthaff.2018.05144.

[iv] Medicare Payment Advisory Commission, Report to the Congress, Medicare Payment Policy. Chapter 11: The Medicare Advantage Program: Status Report. March 2023.

[v] Gilfillan, R and Berwick,DM; Medicare Advantage, Direct Contracting, and the Medicare 'Money Machine, Part 2: Building on the ACO Model. Health Affairs Blog, September 30, 2021.

[vi] **CMS.gov, CMS Innovation Center 2021 Strategy Refresh: Putting All Patients at the Center of Care**

[vii] https://vtmd.org/client_media/files/Principles%20for%20the%20Development%20of%20Pay-for-Performance%20Programs%20-%202023.pdf

[viii] https://vtmd.org/client_media/files/Ethical%20Conflicts%20of%20Pay%20for%20Performance%20-%202023.pdf