# All-Payer Model Update

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# Current All-Payer Model Agreement

- Signatories = Governor, AHS Secretary, GMCB Chair
  - Full GMCB vote required for Chair to sign
- Original period 2018-2022 (5 Performance Years)
- Currently in first year of a two-year extension period
  - Extension: Suggested by CMMI; Board and other signatories approved in November 2022 to act as a bridge to a future federal-state model which was then expected for 2025
  - Currently set to end on 12/31/2024
- Implementation = close AHS-GMCB collaboration

# Sustaining Medicare Participation in Multi-payer Alternative Payment Models in Vermont

**Original Vermont All-Payer ACO Model Agreement** → Amended and Restated Vermont All-Payer ACO Model Agreement → Future potential Vermont Medicare Multi-Payer Agreement

Six Year Agreement (2017-2022)

- The Vermont All-Payer ACO Model Agreement is an arrangement between Vermont and the federal government that allows Medicaid and commercial insurers to pay for health care differently.
- The goal is to shift from paying for each service (fee-for-service) toward paying for high performance and good outcomes (value-based).
- Changing how services are paid for is intended to reduce health care cost growth, maintain quality of care, and improve the health of Vermonters.
- The current model relies on an Accountable Care Organization (OneCare Vermont) to develop a voluntary network of health care providers that agree to be accountable for the care and cost for their attributed patients.



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# Sustaining Medicare Participation in Multi-payer Alternative Payment Models in Vermont

Original Vermont All-Payer ACO Model Agreement → **Amended and Restated Vermont All-Payer ACO Model Agreement** → Future potential Vermont Medicare Multi-Payer Agreement

2023-2024

*Extension of current agreement*

- Vermont and the federal government have executed an extension of the Vermont All-Payer ACO Model Agreement.
- Agreement terms are similar.
- The extension is currently in place for 2023 and the State has accepted the option to extend the Agreement through 2024.
- The extension maintains Medicare investments in Vermont, such as the Blueprint for Health and OneCare's Comprehensive Payment Reform program that support primary care practices.

# Sustaining Medicare Participation in Multi-payer Alternative Payment Models in Vermont

Original Vermont All-Payer ACO Model Agreement → Amended and Restated Vermont All-Payer ACO Model Agreement → **Future potential Vermont Medicare Multi-Payer Agreement**

2025 - ?

- The federal government is developing a multi-state, multi-payer model to be available in future years.
- Vermont is providing feedback on the model's design to the extent possible and will assess the model when it is released to determine if it meets the state's needs.



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# Timeline for Engaging with the Center for Medicare and Medicaid Innovation (CMMI)

**August – December 2022**
**Phase 1 Engagement**

During this phase, the Agency of Human Services convened the Health Care Reform Work Group and advisory groups to provide initial feedback to CMMI on its priorities for a future multi-state, multi-payer alternative payment model.

**January – Late 2023**
**Phase 2 Engagement**

The Agency of Human Services and the Green Mountain Care Board are continuing to meet with CMMI to provide feedback on the potential model's design. The Agency is seeking feedback through public comment, broad stakeholder engagement, and other forums designed to capture input from Vermonters.

**Mid-Late 2023**
**Potential New Multi-State Model Opportunity**

Based on current information, the Agency of Human Services expects a formal opportunity for participation in a multi-state, multi-payer model to be available at some point in 2023. The State needs to submit a proposal in response to the model offering if it wants to participate.

# What are the benefits of continuing to include Medicare in Vermont reform?

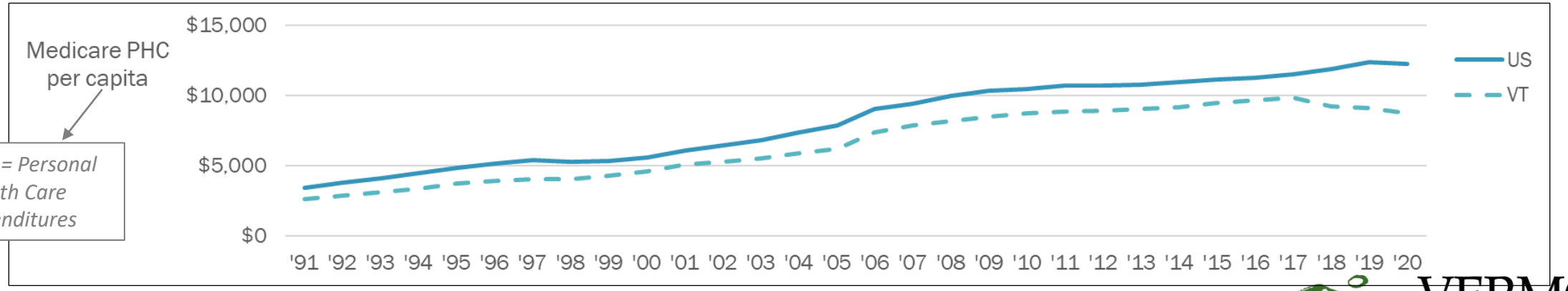
- Continued recognition of Vermont's status as a long-time low-cost state for Medicare
  - If there is a gap in participation between current APM and a subsequent model, Vermont could be subject to a new baseline in calculating a savings target and spending trend. This could be detrimental to Vermonters, Vermont providers, and the State's ability to meet targets and retain savings.
- Ensure that baseline financial calculations recognize Vermont's past reforms that have saved money for Medicare ("Accrued Savings")
- Ability to influence Medicare reimbursement for Vermont providers
- ~$10M annually for Medicare's portion of Blueprint (payments to primary care practices, Community Health Teams, and Support and Services at Home)

# What are the benefits of continuing to include Medicare in Vermont reform? (cont.)

- Waivers of Medicare regulations (e.g., 3-day stay Skilled Nursing Facility waiver) and ability to propose new waivers
- Fundamentally, Medicare flexes to Vermont – this results in greater alignment in priorities, payment models, quality measures/reporting, which sends a stronger signal to all health care system partners
  - If Vermont primary care and specialty care professionals revert to FFS Medicare, they could be subject to significant quality-related payment adjustments via the federal Merit-based Incentive Payment System (MIPS) program and lose benefits related to advanced alternative payment methodology participation.

# Vermont is a Low-Cost State for Medicare

- Medicare per beneficiary spending per enrollee for Vermont residents is far below the national average. Historically, annual Medicare spending growth for Vermont residents was comparable to national averages—some years it may have exceeded national growth rates but in other years it was below.
- In 2017, Vermont entered into the APM with CMMI, and since that model, Vermont's cost growth has dropped sharply compared to national spending.
- In other words, Vermont successfully "bent the cost curve" for Medicare spending. That slower growth has compounded annually, leading to an even greater divergence between Medicare spending in Vermont compared to nationally.



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# Focus and Timing of Future Model

**The Center for Medicare & Medicaid Innovation (CMMI) has provided clarification on the focus and timing of the next model:**

- CMMI is moving in the direction of offering only **multi-state models** rather than state-specific models.
- CMMI has outlined **seven priorities** that will be central to this model (see next slide).
- More details on the model are expected to be released by CMMI in the Fall.
- Applications from states, outlining their proposals, will likely be due in early 2024.
- CMMI has informed Vermont that full implementation of the Medicare payment provisions of this model **will occur in 2026**, not in 2025 as previously anticipated.
- As a result, CMMI and Vermont are negotiating **what 2025 will look like**, with the goal of providing a smooth transition to a new Medicare/multi-payer model in 2026.
- At the same time, CMMI and Vermont are continuing to discuss a potential 2026 model.

# Timeline: Future Federal-State Model

If Vermont chooses to pursue participation in CMMI's anticipated multi-state model, a tentative timeline is below:

| TENTATIVE TIMELINE |
| --- |
| Fall 2023 (tentative): More details on the model are expected to be released<br>• AHS will lead a broader stakeholder engagement process |
| Early 2024 (tentative): Applications from states due, outlining their proposed models<br>• Application would be assembled by AHS and GMCB staff<br>• Public presentations to GMCB, public comment period(s), and vote required before submission |
| Later 2024: Selected states negotiate with CMMI (e.g., on issues like savings targets and Medicare payment model) |
| 2025: Bridge current APM Agreement → CMMI multi-state model<br>• What does the bridge look like? Vermont currently in discussions with CMMI |
| 2026: CMMI multi-state model launch |

# What do we know about the new payment model under development by CMMI?

*"To accelerate and support these efforts, the Innovation Center is exploring a state-based model to improve population-level health outcomes and advance health equity by testing total cost-of-care approaches to shift health care spending and utilization from acute care to primary care. The future state-based, total cost of care models under consideration by the Innovation Center will amplify Medicaid-led advanced primary care efforts by aligning Medicare FFS and other payers to these efforts."*
*- CMS Blog, The CMS Innovation Center's Strategy to Support High-quality Primary Care*

**CMMI is signaling that it will produce a design spanning multiple states that will address 7 priorities:**

| | | |
|---|---|---|
| 1. | Include global budgets for hospitals. | **Payment Design** |
| 2. | Include Total Cost of Care target/approach. | |
| 3. | Be all-payer. | |
| 4. | Include goals for minimum investment in primary care. | |
| 5. | Include safety net providers from the start. | **Core Principles** |
| 6. | Address mental health, substance use disorder, and social determinants of health. | |
| 7. | Address health equity. | |

*Through an advisory group structure and other methods, AHS and GMCB are gathering input on a variety of topics to inform feedback to CMMI on a new multi-payer, multi-state model.*



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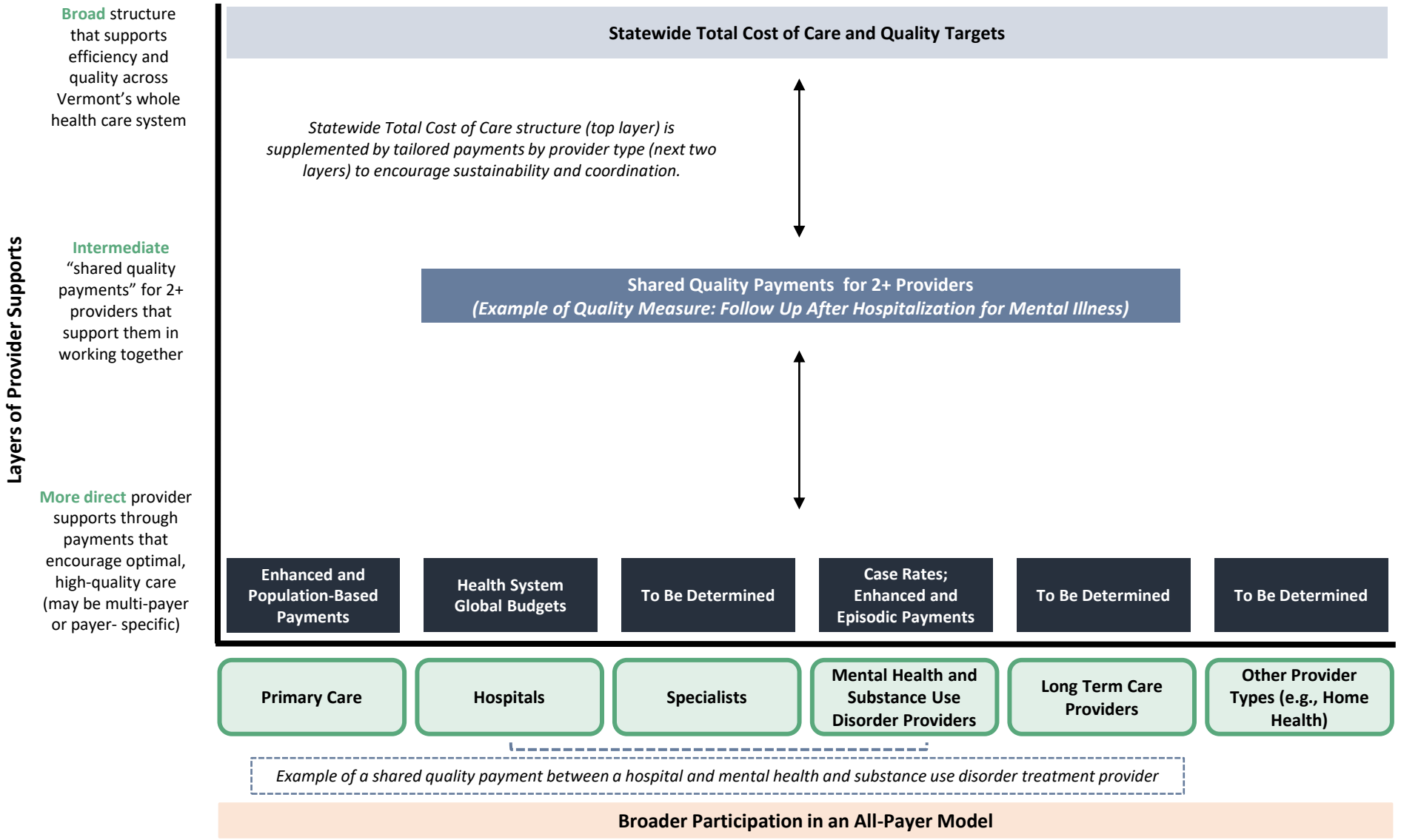
# Vermont's Vision for a Statewide Approach




**Population-Based Payment:** A provider or provider organization is accountable for the health of a group of patients in exchange for a set payment. This gives providers flexibility to coordinate and manage care for their patients. They accept risk for costs of care that exceed the set payment amount.
**Health System Global Budget:** A global budget is a budget that is established ahead for a fixed period of time (typically one year) for a specified set of services (e.g., inpatient and outpatient hospital services) for a set population.
**Case Rate:** A provider receives a flat rate for a patient's treatment for a specific period of time.

# Obtaining Input from Vermonters

**SUMMER 2022**

- Work focused on short-term stability

**FALL 2022**

- Work began to inform discussions on the multi-state, multi-payer model

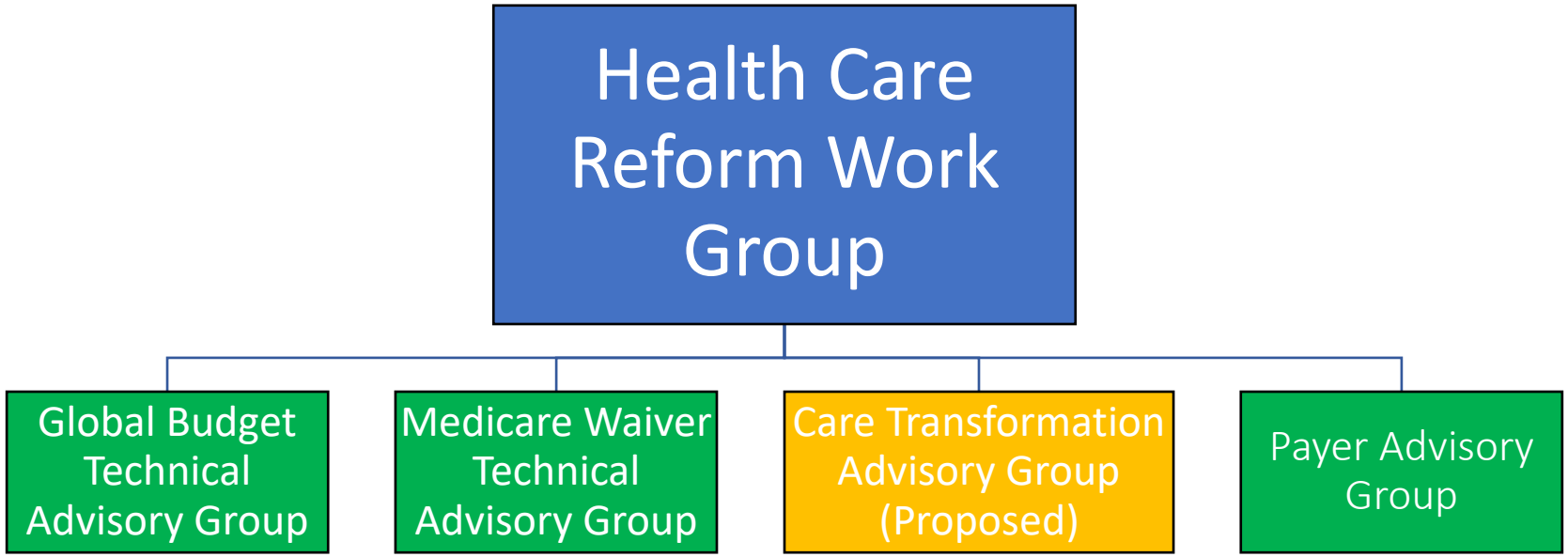
**FEBRUARY 2023**

- Technical discussions began on design of global budget model and Medicare waivers that might be beneficial to Vermont

**LATER IN 2023**

- Mechanisms for public input are available on the GMCB and AHS websites
- Regular updates at GMCB public board meetings and discussions at existing forums

# Current Work Group Structure




***Previous Subgroups from Fall 2022:***

**Global Budgets Subgroup and Total Cost of Care Subgroup**

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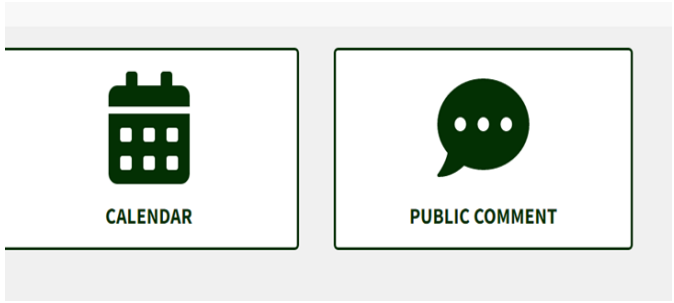
# Participating Organizations: Health Care Reform Work Group

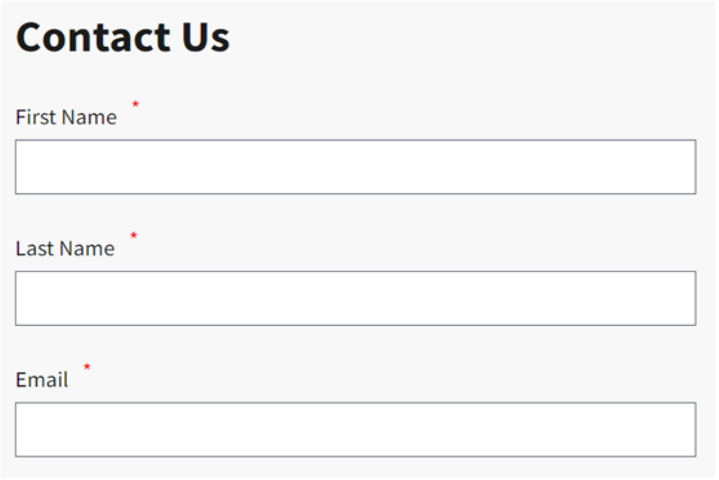
- Bi-State Primary Care Association
- BlueCross BlueShield of Vermont
- Cigna Healthcare
- Counseling Center of Addison County
- Department of VT Health Access
- Gifford Medical Center
- Green Mountain Care Board
- HealthFirst
- MVP Health Care
- Northern Counties Health Care
- OneCare Vermont
- Rutland Regional Medical Center
- Thomas Chittenden Health Center
- University of Vermont Health Network
- Vermont Agency of Human Services
- Vermont Association of Hospitals and Health Systems
- Vermont Care Partners
- Vermont Department of Financial Regulation
- Vermont Health Care Association
- Vermont Medical Society
- VNAs of Vermont
- Visiting Nurse and Hospice for VT and NH

*More than 30 individuals from these participating organizations are on the Work Group.*

# Public Information and Input: AHS and GMCB Websites

- Advisory group meeting materials and summaries posted on GMCB and AHS websites
- Mechanisms for public input:



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# Vermont's Feedback to CMMI

Here are some of Vermont's needs that have been communicated to CMMI to date:

- Support for rural provider stability and sustainability (workforce and inflation are important concerns)
- Increase in predictability of payments
- Ensuring the right amount of revenue (recognition that Vermont is a low-cost state for Medicare)
- Support for investments in preventive and community care
- Making sure payment models and quality measures are aligned across payers as much as possible
- Allowing Vermont to keep moving forward on our important health care reform efforts (care for people with complex health and social needs, support for primary care through programs such as the Blueprint for Health and Comprehensive Payment Reform, support for community-based services)

# Summary of Next Steps

- Continue meeting with CMMI
- Continue gathering input:
  - From work groups
  - From AHS and GMCB advisory groups
  - From presentations at GMCB meetings
  - From public comments
- Carefully review model when it CMMI releases it to see if it is good for Vermont and continue to gather input when formulating a response.