AHEAD Model Update

December 18, 2024

VERMONT
GREEN MOUNTAIN CARE BOARD

VERMONT
AGENCY OF HUMAN SERVICES

Acknowledgements

- We would like to recognize the extensive work of the AHEAD negotiating team and supporting staff:
  - From GMCB (Board Member Robin Lunge, Board Member David Murman, and Staff Member Michele Degree)
  - From AHS (Secretary Jenney Samuelson, Health Care Reform Director Brendan Krause, Administrative Services Director Fran Hodgins, Health Services Researcher Geoff Battista, and most recently, Deputy Health Care Reform Director Sarah Rosenblum)

Background and Context

- Since the acceptance of Vermont into AHEAD in July 2024, the Agency of Human Services (AHS) and the Green Mountain Care Board (GMCB) have jointly been negotiating with CMS on the terms of the potential AHEAD agreement.
- Maryland was the only other state accepted by CMS to commence AHEAD as early as January 2026 ("Cohort 1"). Maryland signed its State Agreement with CMS on November 1, 2024. Maryland's AHEAD State Agreement is publicly available (hscrc.maryland.gov).
- **While Vermont has been accepted into Cohort 1 for the AHEAD Model, the State has not yet signed the State Agreement committing us to participate in AHEAD.**
  - Vermont and CMS have agreed to key terms in the Agreement; over the next month Vermont and CMS will work to finalize the State Agreement language.

Pre-Implementation Period: Key Model Milestones

18 months prior to start of Performance Year 1 / Upon Award (Starting July 2024)

- Initial draft of state-designed Medicare Fee-for-Service (FFS) Hospital Global Budget (HGB) methodology to be submitted to CMS (complete - July 2024)
- Medicaid primary care alternative payment model (APM) and Medicaid HGB "regulatory change" proposals to be submitted to CMS (complete - July 2024)
- Refine and update Medicare FFS HGB methodology and submit to CMS (Early 2025)
- Design EAST Fund (internal state timeline – Fall 2024 to Spring 2025)
- Design Medicaid HGB methodology

6 months after award date (January 2025)

- Establish Model Governance Structure
- **Execution of State Agreement (regardless of cohort selected)**

Negotiations began when the state was selected. Vermont is committed to participating in AHEAD when it signs the State Agreement.

12 months prior to start of Performance Year 1 (January)

- Medicaid HGB methodology to be submitted to CMS (could be January 2025 or January 2026 depending on the cohort selected)

6 months prior to start of Performance Year 1 (July)

- Obtain letters of interest from hospitals interested in participating in Medicare FFS HGBs
- CMS approval of Medicaid HGB methodology
- Draft Executive Order to create total cost of care (TCOC) and primary care spend targets (or process to set targets)

3 months prior to start of Performance Year 1 (October)

- Demonstration of readiness for Medicaid HGB implementation and Medicaid primary care APM
- CMS checks that at least **10%** of Medicare FFS Net Patient Revenue will be under Medicare FFS HGBs as reflected in hospitals' participation agreements
- Finalize Executive Order to create TCOC and primary care spend targets (or process)

End of Pre-Implementation Period (December)

- Finalize Statewide Health Equity Plan

Cohort 1 Pre-implementation Period: July 1, 2024 to December 31, 2025
Cohort 2 Pre-implementation Period: July 1, 2024 to December 31, 2026

Implementation Period: Key Model Milestones

Performance Year 1

January

- Implementation of Medicare Primary Care AHEAD and Medicaid Primary Care APM (i.e., Blueprint for Health) goes live
- Implementation of Medicare HGBs, must include at least **10%** of Medicare FFS hospital net patient revenue (NPR)
- Measurement of Medicare FFS TCOC, Medicare FFS primary care investment, and statewide quality and equity targets begins
- Launch EAST Fund

October

- Final All-Payer TCOC and Primary Care Investment targets (for PYs 2-5 at a minimum) to be memorialized in amended state agreement

December

- Implementation of Medicaid HGBs
- Submit to CMS the State's plan to use available State or legislative or regulatory authority to ensure commercial payer adoption of the commercial HGB methodology

Performance Year 2

January

- Measurement of All-Payer TCOC growth and all-payer primary care investment targets begins
- Implementation of Medicare HGBs, must include at least **50%** of Medicare FFS hospital NPR
- Establish a commercial HGB methodology (no later than PY 2)
- VT ensures at least 1 commercial payer offers a commercial HGB model
- Potential implementation of Medicare primary care capitated track under Primary Care AHEAD (CMS is currently evaluating this option)

Cohort 1 Implementation Period: January 1, 2026 to December 31, 2034 (9 years)
Cohort 2 Implementation Period: January 1, 2027 to December 31, 2034 (8 years)

Implementation Period: Key Model Milestones (cont'd)

Performance Year 3

January

- Implementation of Medicare HGBs, must include at least **80%** of Medicare FFS hospital NPR
- VT ensures commercial payer adoption of the commercial HGB methodology starting PY 3

November

- Finalize Medicare FFS investment and access targets for at least PY 4

Performance Year 4

January

- Implementation of Medicare HGBs, must include at least **80%** of Medicare FFS hospital NPR
- Measurement of Medicare FFS investment and access targets begins

Performance Year 5 and Beyond

January

- Implementation of Medicare HGBs, must include at least **85%** of Medicare FFS hospital NPR

Cohort 1 Implementation Period: January 1, 2026 to December 31, 2034 (9 years)
Cohort 2 Implementation Period: January 1, 2027 to December 31, 2034 (8 years)

AHEAD State Agreement as of 12/16

What is the State Agreement?

The AHEAD Model State Agreement is the binding legal document that Vermont signatories and CMS will execute should they choose to move forward with the Model.

- The draft State Agreement builds on the previously released Term Sheet provisions
- Provisions in the draft State Agreement are still subject to modification and ratification in the final State Agreement, which requires signatures and approval from AHS, the Governor, and GMCB.
- Participation in the AHEAD model is contingent upon the Vermont legislature and executive branch appropriating sufficient resources to the GMCB to independently regulate and for the State to implement the model.
- **Prior to signing the State Agreement, Vermont is not committed to participating in the AHEAD model.**

The draft State Agreement is available on the AHS website and the GMCB website.

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Highlights of State Agreement

(as of 12/16/2024)

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6)	Relevant updates from State Agreement draft (as of 12/16)
Medicare FFS Total Cost of Care target	Approach to setting the historic benchmark	VT will use a 2023 baseline year weighted at 100%. Baseline expenditures will include non-claims-based payments (VTAPM savings and advanced shared savings payments). These will be trended forward using the trend factor as defined in the TCOC methodology. Baseline will exclude 2023 catheter charges. **2023 PBPY: $12,040**	No policy change. Appendix A of the draft State Agreement includes a guardrail provision; in the event that Vermont's Medicare FFS growth in 2024 or 2025 is above the national growth, CMS will account for the Vermont-specific growth in TCOC methodology.

FFS = Fee-for-Service
VTAPM = Vermont All-Payer Model

TCOC = Total Cost of Care
PBPY = Per Beneficiary Per Year

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Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
State Designed Hospital Global Budget	Hospital Global Budget Operations Incentive	The state may include in its Proposed State Designed Hospital Global Budget Methodology a Hospital Global Budget Operations Incentive (HGBOI), similar to the Transformation Incentive Adjustment in the CMS Designed Methodology, to incentivize early participation in hospital global budgets and enable hospital investment in care management and care transformation needed to succeed under a hospital global budget. The HGBOI will be an upward adjustment of no less than 2% and up to 3%. PPS Participant Hospitals are eligible for the HGBOI in PY1 through PY3; CAH participants that join before PY5 are eligible for the HGBOI for the first three years of participation.	No policy change. In response to recent questions regarding the impact of Model participation and/or subsequent exit by CAHs on CAH payment methodology, we have confirmed that participation does not impact CAH designation and would not impact payment methodology.

PPS = Prospective Payment System
CAH = Critical Access Hospital

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
Equity, Access, and Transformation	Equity, Access, and Transformation Fund	To address known challenges in affordability, equity and access to care across the care continuum, Vermont shall establish an Equity Access and Statewide Transformation Fund ("EAST Fund") for Vermont health and community service providers. The EAST Fund may be funded by hospital revenue, as directed by the GMCB under its statewide all-payer hospital budget setting authority and as described in the CMS Approved State Designed Hospital Global Budget Methodology. Activities paid for by the Fund must support achievement of the Statewide Accountability Targets, the goals of the AHEAD Model, and be consistent with Vermont law.	Policy amended to include the addition that GMCB, to the extent permitted under applicable law, may direct one or more hospitals to contribute a specified portion of their hospital revenue to the EAST Fund.

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
Hospital Global Budget	Payer Participation	The State intends to establish hospital global budget payment methods for commercial payers, no later than PY2 and for each subsequent year. The State will assess options to effectuate ERISA-compliant mandatory participation for implementation by PY3, and will notify CMS of its selected option(s) by the end of PY1.	Removed references to ERISA-compliant payers in favor of "Commercial Payer." Commercial Payer was also redefined to refer to health insurance plans holding a certificate of authority from VT's Commissioner of Financial Regulation.

ERISA = Employee Retirement Income Security Act of 1974

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
State Designed Hospital Global Budget	Hospital Global Budget Operations Incentive (HGBOI)	Hospital Global Budget Operations Incentive is only available to participating hospitals. Hospitals that exit the model prior to PY6 will be required to repay to CMS any Hospital Global Budget Operations Incentive payments.	No policy change. Additional clarification included: "If CMS terminates the Model prior to PY6 pursuant to Section 20.h, Participant Hospitals will not be required to repay CMS any HGBOI payments."

Enforcement Provisions in the Draft State Agreement

- CMS may take an enforcement action against the State if CMS determines a Triggering Event has occurred.
- See Section 20 of the draft Agreement for a comprehensive list of Triggering Events. Triggering Events include but are not limited to the following instances of CMS determining that the State has failed to meet and/or establish:
  - Statewide Quality and Equity Targets for PYs 2, 4, 6, or 8.
  - All-Payer TCOC Growth Target in any two PYs within a period of three consecutive PYs.
  - All-Payer Primary Care Investment Targets in any two PYs within a period of three consecutive PYs.
  - Medicaid Hospital Global Budget prior to the end of PY1 or for any subsequent PYs.
  - All-Payer TCOC Growth Targets for PYs 2 through 5, at a minimum, by PY2.
  - Medicare FFS TCOC Target in any two PYs within a period of three consecutive PYs
  - 80% of Medicare FFS NPR under Medicare FFS Hospital Global Budgets by PY3.
  - 85% of Medicare FFS NPR would be under Medicare FFS Hospital Global Budgets by PY5 or any subsequent PY.

Enforcement Provisions in the Draft State Agreement (cont'd)

- Triggering Event Factors
  - CMS may take into account the totality of the circumstances when determining if a Triggering Event occurred.
  - The State may demonstrate that an Exogenous Factor caused the Triggering Event, in whole or in part; or whether a delay in a CMS deliverable required of CMS under this Agreement contributed to the Triggering Event.
- Changes to Payments
  - CMS may adjust Medicare FFS payments under the Model to Participant Hospitals via the Medicare FFS Hospital Global Budget Methodology and/or the EPCP if the following determination or request occurs:
    - If CMS determines a Triggering Event has occurred and the adjustment is intended to correct the Triggering Event; or
    - If the State requests an adjustment to one or more payments before CMS has determined a Triggering Event has occurred and the adjustment is intended to result in performance that avoids a Triggering Event.

Enforcement Provisions in the Draft State Agreement (cont'd)

- If CMS determines that a Triggering Event, as defined in Section 20.b, has occurred, CMS will provide written notice to the State ("**Warning Notice**") with an explanation and, to the extent practicable and permitted by applicable law, data supporting its determination.
- If CMS does not accept the State's response to the Warning Notice as sufficient, CMS may issue a written notice ("**Enforcement Action Notice**"), to the State, outlining the enforcement action(s) CMS is taking against the State.

Enforcement Provisions in the Draft State Agreement (cont'd)

- In the Enforcement Action Notice, CMS will note what enforcement action(s) they are taking against the State. CMS may take one or more of the following enforcement actions:
  - Require the State to submit and implement a corrective action plan (CAP);
  - Require the State, if applicable, to modify its CMS-Approved State-Designed Medicare FFS Hospital Global Budget Methodology;
  - Require the State to provide additional information to CMS;
  - Subject the State to additional monitoring, auditing, or both;
  - Require the State to propose to CMS for approval new safeguards or programmatic features to be added to the Model;
  - Make prospective adjustments to the Medicare FFS Hospital Global Budget payments made to the State's Participant Hospitals and the EPCP made to the Participant Primary Care Practices;
  - Modify or terminate a Medicare payment waiver or waivers

Termination Provisions in the Draft State Agreement

- Section 20(h) – CMS may terminate if the State fails to submit, obtain approval for, implement or comply with a CAP or the State has not complied with CMS enforcement. CMS will terminate if the Medicare HGB methodology is not approved by April 1, 2025.
- Triggering events include:
  - Failing to meet the state accountability requirements, including Medicare and All-Payer TCOCs; Medicare and All-Payer Primary Care Targets; Medicare FFS Investment and Access Targets; Statewide Quality and Equity Targets
  - Requirements must be met 2/3 consecutive years, except quality & equity targets are measured in even years only
  - Failing to implement a component of the AHEAD model, including a Medicaid Advance Primary Care Program (e.g. the Blueprint); a Medicaid HGB; establishment of the all-payer targets; failing to meet the HGB participation requirements for hospitals and commercial payers
  - Noncompliance with the Cooperative Agreement (e.g., use of federal funds) & failure to maintain CMS requirements for data integrity (status as a CMS Health Oversight Agency)
  - Less than 10k beneficiaries in Medicare FFS
  - Actions inconsistent with the AHEAD goals, including actions that threaten the health or safety of Medicare patients; compromising the integrity of the Model or Medicare Trust Fund; deterioration of quality for Medicare, Medicaid or CHIP patients; enactment of legislation/regulation that inhibits the ability of the State or payers to participate or are inconsistent with the requirements of the Agreement
  - False representations by the state or submission of false data by the State
  - Failing to meet the hospital participation requirements in PY3 and PY5-9; failing to meet the payer participation requirement in PY2

Termination Provisions in the Draft State Agreement (cont'd)

2. Section 20(j) – Section 1115A(b)(3)(B) – Federal law allowing for CMMI demonstration projects/authorizing AHEAD and other models
    a. (B) Termination or modification.—The [HHS] Secretary shall terminate or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary of CMS, with respect to program spending under the applicable title, certifies), after testing has begun, that the model is expected to—
        a. (i) improve the quality of care (as determined by the Administrator of CMS) without increasing spending under the applicable title;
        b. (ii) reduce spending under the applicable title without reducing the quality of care; or
        c. (iii) improve the quality of care and reduce spending.
        d. Such termination may occur at any time after such testing has begun and before completion of the testing
3. Section 20(i) – The **State** may terminate for:
    a. Any reason upon 180 days notice (at any time)
    b. Any reason upon 30 days notice in the pre-implementation period (2026 for Cohort 1; 2027 for Cohort 2)

Hospital Global Budget Methodology

- Model is premised on GMCB's hospital budget review authority and maintenance of budget review
- Timeline: State must submit a revision by Jan 31, 2025; must be approved by April 1st or CMS will terminate the model. Outlines process for modifying the methodology over time
- Operations: Current draft from CMMI allows for 2 options for operationalizing the State-Designed Medicare Global Budget:
    1. CMS will calculate using their methodology + Hospital Global Budget Operations Incentive (HGBOI); One or more hospital budgets would include Blueprint and SASH dollars and funds to go into the EAST Fund
    2. State may calculate its methodology as submitted & further revised; CMS will validate its calculation.
- In either option, hospitals may request modifications. State will review and make a recommendation to CMS.
- Service line adjustment process is outlined; requires State recommendation and CMS approval.
- Default in current draft is Option 1, but State has not decided this yet.

Discussion

Appendix

Additional Term Sheet Provisions – No Changes Since 12/6/24

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
Primary Care	Enhanced Primary Care Payment (EPCP) amount	Average of $17 PBPM, with a minimum of $15 and maximum of $21. EPCP will be adjusted for inflation annually beginning in PY2.	No policy change.

PBPM = Per Beneficiary Per Month
PY = Performance Year

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
Primary Care	Care Transformation Requirements	Vermont's statewide Blueprint for Health program, supporting integrated health and community services and advanced primary care, is expected to meet the care transformation requirements in Primary Care AHEAD. To the extent possible, CMS will repurpose the practice and health service area reporting to the State under the Blueprint for the purpose of the reporting requirements of Primary Care AHEAD. By PY4, the state will ensure the Blueprint for Health care transformation requirements evolve to align with the state's investment and access targets (i.e., to include specialist referrals, specialty care coordination and integration).	No policy change.

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
Medicare FFS PCI target	Medicare FFS Primary Care Investment Target	Maintain existing investment (4.47%) with a final attainment target of 5.17% as calculated by CMS by PY9. Interim targets are to be determined.	No policy change.

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
Medicare FFS PCI target	Medicare FFS primary Care Investment Target	CMS will include Blueprint funding (CHT + SASH) that was included in VTAPM in PC spending for the purposes of calculating the Medicare FFS and All-Payer PCI target.	No policy change.

PCI = Primary Care Investment
CHT = Community Health Team
SASH = Support and Services at Home Program
PC = Primary Care

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
State Access to Care Goals	Investment and Access Targets	By PY4, the state must include specific Medicare FFS Investment and Access Targets for services or providers identified as historically underfunded and/or underutilized, to include home health, skilled nursing, mental health, substance use, and selected specialty care related to the Statewide Accountability Targets. The State will submit Investment and Access Targets aligned with AHEAD goals in a State Transformation Plan in conjunction with the Statewide Health Equity Plan, subject to CMS approval. The state may update these Investment and Access Targets in subsequent PYs, subject to CMS approval. The Investment and Access Targets are considered part of the Statewide Accountability Targets.	No policy change.

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
Medicare FFS TCOC target	Cumulative Savings / Average Savings Component	There will be an expectation of greater than budget neutrality. Vermont must show gross savings beginning in PY1; net savings beginning in PY4. Average cumulative savings over the life of the model: 0.53% below the trend. On an annual basis, this represents a savings component of 0.1% below the trend. Based on current assumptions, Savings are estimated to be about $79.7M over 9 PYs. Estimated savings figures are illustrative only and will not be included in the State Agreement or Accountability Targets.	No policy change.

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
Hospital Global Budget	Hospital Participation	The State will use its authority to ensure that at least 10 percent of the Medicare FFS Net Patient Revenue for eligible Vermont hospitals is under a Medicare Hospital Global Budget for PY1, 50 percent in PY2, 80% in PY3 and PY4, and 85% in PY5 and each subsequent PY.	No policy change.

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
Enforcement Action and Termination	Termination by the State	The State may terminate the Agreement at any time during the Pre-Implementation period for any reason with 30 days advanced notice to CMS.	No policy change.

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
Cooperative Agreement	Cohort Selection	The state is evaluating the model for participation in Cohort 1 and may elect to move to Cohort 2 prior to executing the State Agreement, or April 1, 2025, whichever comes first.	No policy change.

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
Medicare FFS TCOC target	Trend	Vermont will use the weighted average of the United States Per Capita Costs (USPCC) and AHEAD Accountable Care Prospective Trend (ACPT)	No policy change.

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
Medicare FFS TCOC target	Savings Component Schedule	Constant: 0.1% annually	No policy change.

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
Medicare FFS TCOC target	Out of state spending	Because Vermont's total out of state spending exceeds 30% of TCOC, if CMS's calculation of TCOC performance demonstrates that the State's out-of-state spending is the cause of the State exceeding its annual Medicare FFS TCOC Target or All-Payer TCOC Growth Target in any two PYs within a period of three consecutive PYs, CMS will not issue a Warning Notice or Enforcement Action.	No policy change.

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
Hospital Global Budget	AAPM status	CMS will evaluate VT's proposed Medicare HGB methodology to determine if it meets criteria to receive AAPM status. CMS is also available to provide TA on AAPM status.	No policy change.

AAPM = Advanced Alternative Payment Model
TA = Technical Assistance

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
State Designed Hospital Global Budget	Corrective Action	If the State has less than 80% of Medicare FFS net patient revenue in a global budget in PY3 or less than 85% by PY5 or any subsequent PY, CMS will issue a Warning Notice and may pursue corrective action.	No policy change.

Updates to AHEAD Model Terms in the Draft State Agreement

Category	Term	Policy (as of 12/6/24)	Relevant updates from State Agreement draft (as of 12/16)
Hospital Global Budget	Blueprint	Vermont shall include in the Proposed State Designed Hospital Global methods how Blueprint funds will be directed to one or more hospital(s) and then directed to Blueprint and SASH, and how the State will hold the hospital(s) accountable for ensuring the Blueprint and SASH funds are distributed.	No policy change.

Appendix: Previously presented on 12/9/2024

AHEAD Model Update

December 9, 2024

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Appendix: Previously presented on 12/9/2024

Acknowledgements

- We would like to recognize the extensive work of the AHEAD negotiating team and supporting staff:
  - From GMCB (Board Member Robin Lunge, Board Member David Murman, and Staff Member Michele Degree)
  - From AHS (Secretary Jenney Samuelson, Health Care Reform Director Brendan Krause, Administrative Services Director Fran Hodgins, Health Services Researcher Geoff Battista, and most recently, Deputy Health Care Reform Director Sarah Rosenblum)

Appendix: Previously presented on 12/9/2024

Background and Context (1 of 2)

- Vermont engaged in extensive work prior to applying for the AHEAD Model through the multi-stakeholder Health Care Reform Work Group and several subgroups.
  - Beginning in Summer 2022, the Short-Term Provider Stability Subgroup developed workforce, system flow, revenue and regulation recommendations to improve short-term provider stability.
  - Beginning in Fall 2022, work began to compare models and establish a framework to inform discussions on a future multi-payer model.
  - Beginning in February 2023, technical subgroups began discussions on design of a Vermont-specific hospital global budget methodology and Medicare waivers that might be beneficial to Vermont.
- Vermont also engaged in regular discussions with the Centers for Medicare & Medicaid Services (CMS) to learn more about and provide input on AHEAD Model design.

Appendix: Previously presented on 12/9/2024

Background and Context (2 of 2)

- Since the acceptance of Vermont into AHEAD in July 2024, the Agency of Human Services (AHS) and the Green Mountain Care Board (GMCB) have jointly been negotiating with CMS on the terms of the potential AHEAD agreement.
- Maryland was the only other state accepted by CMS to commence AHEAD as early as January 2026 ("Cohort 1"). Maryland signed its State Agreement with CMS on November 1, 2024. Maryland's AHEAD State Agreement is publicly available (hscrc.maryland.gov).
- **While Vermont has been accepted into Cohort 1 for the AHEAD Model, the State has not yet signed the State Agreement committing us to participate in AHEAD.**
  - Vermont and CMS have agreed to key terms in the Agreement; over the next month Vermont and CMS working to finalize the State Agreement language.

AHEAD Model At-A-Glance

The States Advancing All-Payer Health Equity Approaches and Development, or the AHEAD Model, is a flexible framework designed to improve health outcomes across multiple states.

Statewide Accountability Targets

Total Cost of Care Growth (Medicare & All-Payer)
Primary Care Investment (Medicare & All-Payer)
Equity and Population Health Outcomes via State Agreements with CMS

8-9 Performance Years

Components

- Cooperative Agreement Funding
- Hospital Global Budgets (facility services)
- Primary Care AHEAD

Strategies

- Equity Integrated Across Model
- Behavioral Health Integration
  - In lieu of "Behavioral Health", VT uses the term "Mental Health and Substance Use Disorder Treatment"
- All-Payer Approach
- Medicaid Alignment
- Accelerating Existing State Innovations

Source: CMS Presentation from September 26, 2023 AHEAD Model Overview Webinar

Appendix: Previously presented on 12/9/2024

AHEAD Model Term Sheet

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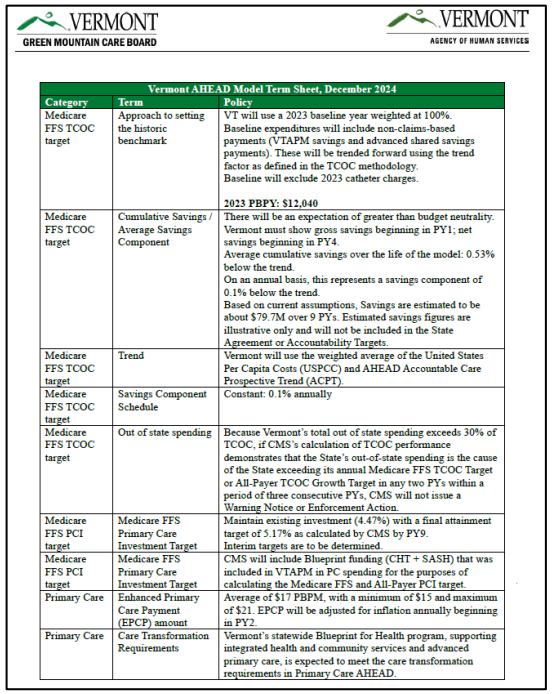
What is the Term Sheet?

Appendix: Previously presented on 12/9/2024

The AHEAD Model Term Sheet is a statement of key points of agreement between Vermont and CMS.



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Vermont AHEAD Model Term Sheet, December 2024

Category	Term	Policy
Medicare FFS TCOC target	Approach to setting the historic benchmark	VT will use a 2023 baseline year weighted at 100%. Baseline expenditures will include non-claims-based payments (VTAPM savings and advanced shared savings payments). These will be trended forward using the trend factor as defined in the TCOC methodology. Baseline will exclude 2023 catheter charges. **2023 PBPY: $12,040**
Medicare FFS TCOC target	Cumulative Savings / Average Savings Component	There will be an expectation of greater than budget neutrality. Vermont must show gross savings beginning in PY1; net savings beginning in PY4. Average cumulative savings over the life of the model: 0.53% below the trend. On an annual basis, this represents a savings component of 0.1% below the trend. Based on current assumptions, Savings are estimated to be about $79.7M over 9 PYs. Estimated savings figures are illustrative only and will not be included in the State Agreement or Accountability Targets.
Medicare FFS TCOC target	Trend	Vermont will use the weighted average of the United States Per Capita Costs (USPCC) and AHEAD Accountable Care Prospective Trend (ACPT).
Medicare FFS TCOC target	Savings Component Schedule	Constant: 0.1% annually
Medicare FFS TCOC target	Out of state spending	Because Vermont's total out of state spending exceeds 30% of TCOC, if CMS's calculation of TCOC performance demonstrates that the State's out-of-state spending is the cause of the State exceeding its annual Medicare FFS TCOC Target or All-Payer TCOC Growth Target in any two PYs within a period of three consecutive PYs, CMS will not issue a Warning Notice or Enforcement Action.
Medicare FFS PCI target	Medicare FFS Primary Care Investment Target	Maintain existing investment (4.47%) with a final attainment target of 5.17% as calculated by CMS by PY9. Interim targets are to be determined.
Medicare FFS PCI target	Medicare FFS Primary Care Investment Target	CMS will include Blueprint funding (CHT + SASH) that was included in VTAPM in PC spending for the purposes of calculating the Medicare FFS and All-Payer PCI target.
Primary Care	Enhanced Primary Care Payment (EPCP) amount	Average of $17 PBPM, with a minimum of $15 and maximum of $21. EPCP will be adjusted for inflation annually beginning in PY2.
Primary Care	Care Transformation Requirements	Vermont's statewide Blueprint for Health program, supporting integrated health and community services and advanced primary care, is expected to meet the care transformation requirements in Primary Care AHEAD.

- The terms outlined in the Term Sheet are not final, and the State anticipates that there may be changes to the terms based on further negotiations.
- The Term Sheet and all provisions therein are subject to modification and ratification in a subsequent State Agreement, which requires signatures and approval from AHS, the Governor, and GMCB.
- The Term Sheet is nonbinding and is not a formal action of GMCB.
- Participation in the AHEAD model is contingent upon the Vermont legislature and executive branch appropriating sufficient resources to the GMCB to independently regulate and for the State to implement the model.
- **Prior to signing the State Agreement, Vermont is not committed to participating in the AHEAD model.**

The Term Sheet is available on the AHS website and the GMCB website.

Appendix: Previously presented on 12/9/2024

Highlights of AHEAD Model Terms

(as of 12/6/2024)

VERMONT GREEN MOUNTAIN CARE BOARD

VERMONT AGENCY OF HUMAN SERVICES

Appendix: Previously presented on 12/9/2024

AHEAD Model Terms

Category	Term	Policy
Medicare FFS Total Cost of Care target	Approach to setting the historic benchmark	VT will use a 2023 baseline year weighted at 100%. Baseline expenditures will include non-claims-based payments (VTAPM savings and advanced shared savings payments). These will be trended forward using the trend factor as defined in the TCOC methodology. Baseline will exclude 2023 catheter charges. **2023 PBPY: $12,040**

FFS = Fee-for-Service
VTAPM = Vermont All-Payer Model
TCOC = Total Cost of Care
PBPY = Per Beneficiary Per Year

AHEAD Model Terms

Appendix: Previously presented on 12/9/2024

Category	Term	Policy
Primary Care	Enhanced Primary Care Payment (EPCP) amount	Average of $17 PBPM, with a minimum of $15 and maximum of $21. EPCP will be adjusted for inflation annually beginning in PY2.

PBPM = Per Beneficiary Per Month
PY = Performance Year

AHEAD Model Terms

Appendix: Previously presented on 12/9/2024

Category	Term	Policy
Primary Care	Care Transformation Requirements	Vermont's statewide Blueprint for Health program, supporting integrated health and community services and advanced primary care, is expected to meet the care transformation requirements in Primary Care AHEAD. To the extent possible, CMS will repurpose the practice and health service area reporting to the State under the Blueprint for the purpose of the reporting requirements of Primary Care AHEAD. By PY4, the state will ensure the Blueprint for Health care transformation requirements evolve to align with the state's investment and access targets (i.e., to include specialist referrals, specialty care coordination and integration).

AHEAD Model Terms

Appendix: Previously presented on 12/9/2024

Category	Term	Policy
Medicare FFS PCI target	Medicare FFS Primary Care Investment Target	Maintain existing investment (4.47%) with a final attainment target of 5.17% as calculated by CMS by PY9. Interim targets are to be determined.

AHEAD Model Terms

Appendix: Previously presented on 12/9/2024

Category	Term	Policy
Medicare FFS PCI target	Medicare FFS primary Care Investment Target	CMS will include Blueprint funding (CHT + SASH) that was included in VTAPM in PC spending for the purposes of calculating the Medicare FFS and All-Payer PCI target.

PCI = Primary Care Investment
CHT = Community Health Team
SASH = Support and Services at Home Program
PC = Primary Care

Appendix: Previously presented on 12/9/2024

AHEAD Model Terms

Category	Term	Policy
State Designed Hospital Global Budget	Hospital Global Budget Operations Incentive	The state may include in its Proposed State Designed Hospital Global Budget Methodology a Hospital Global Budget Operations Incentive (HGBOI), similar to the Transformation Incentive Adjustment in the CMS Designed Methodology, to incentivize early participation in hospital global budgets and enable hospital investment in care management and care transformation needed to succeed under a hospital global budget. The HGBOI will be an upward adjustment of no less than 2% and up to 3%. PPS Participant Hospitals are eligible for the HGBOI in PY1 through PY3; CAH participants that join before PY5 are eligible for the HGBOI for the first three years of participation.

PPS = Prospective Payment System
CAH = Critical Access Hospital

Appendix: Previously presented on 12/9/2024

AHEAD Model Terms

Category	Term	Policy
Equity, Access, and Transformation	Equity, Access, and Transformation Fund	To address known challenges in affordability, equity and access to care across the care continuum, Vermont shall establish an Equity Access and Statewide Transformation Fund ("EAST Fund") for Vermont health and community service providers. The EAST Fund may be funded by hospital revenue, as directed by the GMCB under its statewide all-payer hospital budget setting authority and as described in the CMS Approved State Designed Hospital Global Budget Methodology. Continued use of Vermont's CMS-Approved State Designed Hospital Global Budget Methodology is subject to compliance with the Medicare FFS TCOC savings targets and the hospital participation requirements described above. Activities paid for by the Fund must support achievement of the Statewide Accountability Targets, the goals of the AHEAD Model, and be consistent with Vermont law.

AHEAD Model Terms

Appendix: Previously presented on 12/9/2024

Category	Term	Policy
State Access to Care Goals	Investment and Access Targets	By PY4, the state must include specific Medicare FFS Investment and Access Targets for services or providers identified as historically underfunded and/or underutilized, to include home health, skilled nursing, mental health, substance use, and selected specialty care related to the Statewide Accountability Targets. The State will submit Investment and Access Targets aligned with AHEAD goals in a State Transformation Plan in conjunction with the Statewide Health Equity Plan, subject to CMS approval. The state may update these Investment and Access Targets in subsequent PYs, subject to CMS approval. The Investment and Access Targets are considered part of the Statewide Accountability Targets, and will be included as a Triggering Event.

Appendix: Previously presented on 12/9/2024

AHEAD Model Terms

Category	Term	Policy
Medicare FFS TCOC target	Cumulative Savings / Average Savings Component	There will be an expectation of greater than budget neutrality. Vermont must show gross savings beginning in PY1; net savings beginning in PY4. Average cumulative savings over the life of the model: 0.53% below the trend. On an annual basis, this represents a savings component of 0.1% below the trend. Based on current assumptions, Savings are estimated to be about $79.7M over 9 PYs. Estimated savings figures are illustrative only and will not be included in the State Agreement or Accountability Targets.

Appendix: Previously presented on 12/9/2024

AHEAD Model Terms

Category	Term	Policy
Hospital Global Budget	Payer Participation	The State intends to establish hospital global budget payment methods for commercial payers, no later than PY2 and for each subsequent year. The State will assess options to effectuate ERISA-compliant mandatory participation for implementation by PY3, and will notify CMS of its selected option(s) by the end of PY1.

ERISA = Employee Retirement Income Security Act of 1974

AHEAD Model Terms

Appendix: Previously presented on 12/9/2024

Category	Term	Policy
Hospital Global Budget	Hospital Participation	The State will use its authority to ensure that at least 10 percent of the Medicare FFS Net Patient Revenue for eligible Vermont hospitals is under a Medicare Hospital Global Budget for PY1, 50 percent in PY2, 80% in PY3 and PY4, and 85% in PY5 and each subsequent PY.

AHEAD Model Terms

Appendix: Previously presented on 12/9/2024

Category	Term	Policy
Enforcement Action and Termination	Termination by the State	The State may terminate the Agreement at any time during the Pre-Implementation period for any reason with 30 days advanced notice to CMS.

AHEAD Model Terms

Appendix: Previously presented on 12/9/2024

Category	Term	Policy
Cooperative Agreement	Cohort Selection	The state is evaluating the model for participation in Cohort 1 and may elect to move to Cohort 2 prior to executing the State Agreement, or April 1, 2025, whichever comes first.

Appendix: Previously presented on 12/9/2024

Additional AHEAD Model Terms

(as of 12/6/2024)

VERMONT GREEN MOUNTAIN CARE BOARD

VERMONT AGENCY OF HUMAN SERVICES

AHEAD Model Terms

Appendix: Previously presented on 12/9/2024

Category	Term	Policy
Medicare FFS TCOC target	Trend	Vermont will use the weighted average of the United States Per Capita Costs (USPCC) and AHEAD Accountable Care Prospective Trend (ACPT)

AHEAD Model Terms

Appendix: Previously presented on 12/9/2024

Category	Term	Policy
Medicare FFS TCOC target	Savings Component Schedule	Constant: 0.1% annually

AHEAD Model Terms

Appendix: Previously presented on 12/9/2024

Category	Term	Policy
Medicare FFS TCOC target	Out of state spending	Because Vermont's total out of state spending exceeds 30% of TCOC, if CMS's calculation of TCOC performance demonstrates that the State's out-of-state spending is the cause of the State exceeding its annual Medicare FFS TCOC Target or All-Payer TCOC Growth Target in any two PYs within a period of three consecutive PYs, CMS will not issue a Warning Notice or Enforcement Action.

AHEAD Model Terms

Appendix: Previously presented on 12/9/2024

Category	Term	Policy
Hospital Global Budget	AAPM status	CMS will evaluate VT's proposed Medicare HGB methodology to determine if it meets criteria to receive AAPM status. CMS is also available to provide TA on AAPM status.

AAPM = Advanced Alternative Payment Model
TA = Technical Assistance

AHEAD Model Terms

Appendix: Previously presented on 12/9/2024

Category	Term	Policy
State Designed Hospital Global Budget	Hospital Global Budget Operations Incentive	Hospital Global Budget Operations Incentive is only available to participating hospitals. Hospitals that exit the model prior to PY6 will be required to repay to CMS any Hospital Global Budget Operations Incentive payments.

AHEAD Model Terms

Appendix: Previously presented on 12/9/2024

Category	Term	Policy
State Designed Hospital Global Budget	Corrective Action	If the State has less than 80% of Medicare FFS net patient revenue in a global budget in PY3 or less than 85% by PY5 or any subsequent PY, CMS will issue a Warning Notice and may pursue corrective action.

AHEAD Model Terms

Appendix: Previously presented on 12/9/2024

Category	Term	Policy
Hospital Global Budget	Blueprint	Vermont shall include in the Proposed State Designed Hospital Global methods how Blueprint funds will be directed to one or more hospital(s) and then directed to Blueprint and SASH, and how the State will hold the hospital(s) accountable for ensuring the Blueprint and SASH funds are distributed.

Appendix: Previously presented on 12/9/2024

Timeline and Key Themes from Public Comments

Board Process & Timeline

Appendix: Previously presented on 12/9/2024

Date	Topic
Ongoing Public Comment Period	
December 9	Overview of Term Sheet
December 9 - 31	Negotiating team continues to work with CMMI to update State Agreement; ongoing review and consideration of public comments
January 1 – 8	Negotiating team finalizes State Agreement with CMMI
January 8	Negotiating team presents final State Agreement & prepares for Board vote (a vote is noticed for this day)
January 15	Board vote noticed
January 17	All parties sign State Agreement

Public Comment

Appendix: Previously presented on 12/9/2024

- Ongoing public comment period on the AHEAD model since 2023
- Overarching Themes:
  - Funding for Primary Care
  - Access & affordability concerns
    - Primary care
    - Mental health and substance use disorder care
  - Analytic requests
    - Cost/Benefit analyses
    - Fee-for-service counterfactuals
    - Reference-based pricing
  - Administrative burden
    - Advanced Alternative Payment Model Status (MIPS/MACRA exemption)
  - Voluntary/Mandatory participation