# All-Payer Health Equity Approaches and Development (AHEAD) Model Term Sheet

December 5, 2024

Since July 2024, the Vermont Agency of Human Services and the Green Mountain Care Board have been negotiating with the Centers for Medicare and Medicaid Services (CMS) Innovation Center on the terms by which the State of Vermont might participate in the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. The AHEAD model is up to a 9-year model in which the State would be responsible for the Total Cost of Care with the goal of driving health care transformation and multi-payer alignment. Key components of the model include hospital global budgets, primary care investments, and the opportunity to reinvest funding under the Total Cost of Care.

While the parties remain in negotiations, this AHEAD Model Term Sheet is a summary of where the parties currently stand on key points:

- 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 the Agency of Human Services, the Governor, and the Green Mountain Care Board.

- The Term Sheet is nonbinding and is not a formal action of the Green Mountain Care Board.

- Participation in the AHEAD model is contingent upon the Vermont legislature and executive branch appropriating sufficient resources to the Green Mountain Care Board 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.**

Please submit any questions or comments about the AHEAD Model Term Sheet using the Green Mountain Care Board's public comment form.

| Vermont AHEAD Model Term Sheet, December 2024 | | |
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| **Category** | **Term** | **Policy** |
| Medicare FFS TCOC target | Approach to setting the historic benchmark | VT will use a 2023 baseline year weighted at 100%.<br>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.<br>Baseline will exclude 2023 catheter charges.<br><br>**2023 PBPY: $12,040** |
| Medicare FFS TCOC target | Cumulative Savings / Average Savings Component | There will be an expectation of greater than budget neutrality.<br>Vermont must show gross savings beginning in PY1; net savings beginning in PY4.<br>Average cumulative savings over the life of the model: 0.53% below the trend.<br>On an annual basis, this represents a savings component of 0.1% below the trend.<br>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.<br>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. |

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| | | 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.<br>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). |
| 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. |
| 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. |
| 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. |
| 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.<br><br>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. |
| 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.<br>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. |
| 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. |
| 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 |

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| | | 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.<br>The state may update these Investment and Access Targets in subsequent PYs, subject to CMS approval.<br>The Investment and Access Targets are considered part of the Statewide Accountability Targets, and will be included as a Triggering Event. |
| Equity, Access, and Transformation | Equity Access and Statewide 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. |
| 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. |
| 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. |
| 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. |