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The States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model State Agreement

This States Advancing All-Payer Health Equity Approaches and Development Model State Agreement ("**Agreement**") is entered into by and between the Centers for Medicare & Medicaid Services ("**CMS**") and the Governor of Vermont, the Vermont Agency of Human Services ("**AHS**"), and the Green Mountain Care Board ("GMCB") (collectively, "**State**" or "**Vermont**"). The State and CMS are hereinafter collectively referred to as "**the Parties**."

RECITALS

CMS is the agency within the U.S. Department of Health and Human Services ("**HHS**") that is charged with administering the Medicare and Medicaid programs. CMS is implementing the States Advancing All-Payer Health Equity Approaches and Development Model (the "**Model**" or "**AHEAD**") under Section 1115A of the Social Security Act (the "**Act**"), which authorizes CMS, through its Center for Medicare and Medicaid Innovation (the "**Innovation Center**"), to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, or Children's Health Insurance Program ("**CHIP**") expenditures while maintaining or improving the quality of beneficiaries' care. AHEAD is a voluntary, state-based alternative payment and service delivery model designed to test whether a flexible framework that includes statewide accountability targets for all-payer and Medicare fee-for-service ("**FFS**") cost growth, primary care investment, and equity and population health outcomes results in lower cost growth, improved population health, and greater health equity among Medicare FFS beneficiaries and all residents of the State.

The AHS is the Vermont Medicaid Single State Agency (the "**Agency**"). AHS was created by the Vermont Legislature in 1969 to serve as the umbrella organization for all human service activities within the State government. The Agency is led by the AHS Secretary, who is appointed by the Governor. The AHS Secretary's Office is responsible for leading the Agency and its departments which include the Department of Vermont Health Access, the Department of Mental Health, the Department of Health, the Department of Children and Families, the Department of Disabilities, Aging and Independent Living, and the Department of Corrections. AHS manages Vermont's Medicaid program through the terms and conditions of Vermont's Demonstration Waiver under Section 1115 of the Act.

The Green Mountain Care Board ("GMCB"), established in 2011 by the Vermont Legislature, is an independent state government entity with responsibility for advancing innovation in health care payment and delivery, serving as a transparent source of information and analysis on health system performance, and regulating major areas of Vermont's health care system. The GMCB is responsible for review of hospital budgets and health insurance rates, certificate of need assessments for capital improvements and new services, and Accountable Care Organization budget review and certification in Vermont as part of an overall charge of managing cost growth while ensuring high quality of care.

CMS and the State agree the Parties entered into a cooperative agreement on July 1, 2024 (the "**Cooperative Agreement**"), to establish terms, conditions, and critical milestones the State must meet for initial and continued receipt of funding under the Model. CMS hereby incorporates all requirements of the Cooperative Agreement into this Agreement.
The Parties therefore agree as follows:

1. **Agreement Term.**
    a. **Effective Date.** The effective date of this Agreement (the "**Effective Date**") is the date this Agreement is fully executed by all Parties, as indicated by the last signature date. If a Party signs the Agreement and fails to date the signature, the date that the other Party receives the signing Party's signature will be deemed to be the date that the signing Party signed this Agreement.

    b. **Term of the Agreement.** The term of the Agreement (the "**Agreement Term**") begins on the Effective Date and expires two years after the last day of the Transition Period of the Model.

    c. **Pre-Implementation Period.** CMS and the State agree the Pre-Implementation Period began on July 1, 2024 and ends at 11:59 PM ET on December 31, 2025.

    d. **Implementation Period.**
        i. The Implementation Period begins on January 1, 2026 (the "**Start Date**") and ends at 11:59 PM ET on December 31, 2034, unless the Implementation Period is sooner terminated in accordance with Section 20. The Implementation Period consists of the following 12-month Performance Years (PYs):
            1. PY 1: January 1, 2026 – December 31, 2026

2. PY 2: January 1, 2027 – December 31, 2027
3. PY 3: January 1, 2028 – December 31, 2028
4. PY 4: January 1, 2029 – December 31, 2029
5. PY 5: January 1, 2030 – December 31, 2030
6. PY 6: January 1, 2031 – December 31, 2031
7. PY 7: January 1, 2032 – December 31, 2032
8. PY 8: January 1, 2033 – December 31, 2033
9. PY 9: January 1, 2034 – December 31, 2034

e. **Transition Period.**

i. For the State and Participant Hospitals, the Transition Period will consist of up to 24 months beginning upon the conclusion or termination of the Implementation Period of the Model. The length of the Transition Period is determined by the following conditions:

1. If the Implementation Period of the Model is terminated pursuant to Section 20.h prior to the end of PY5, then the Transition Period will be for 12 months, beginning on the effective date of such termination.
2. If the Implementation Period of the Model is terminated pursuant to Section 20.h after the start of PY6, then the Transition Period will be for 24 months, beginning on the effective date of such termination.
3. If the Implementation Period of the Model concludes at the end of PY9, then the Transition Period will be for 24 months, beginning at the conclusion of PY9.

ii. **Transition Period Activities**. During the Transition Period, CMS and the State will engage in the following activities:

1. If the Model is expanded by CMS or CMS implements a new state-based total cost of care model that the State will participate in after the conclusion or termination of the Model, CMS and the State will prepare to implement the expanded Model or new model during the Transition Period. The State will remain subject to the Medicare FFS TCOC Target described in Section 10.a until the start date of the model expansion or new model.
2. If the Model is not expanded and a new model test is not implemented, or if the Transition Period is triggered prior to December 31, 2034 due to termination of

the Implementation Period in accordance with Section 20, Participant Hospitals will transition to the national Medicare FFS payment system over the course of the Transition Period and CMS will take all other actions necessary to wind down the Model test.

iii. **Monitoring:** The State will continue its monitoring activities in accordance with Section 17 of the Agreement throughout the Transition Period.

2. Definitions.

a. **"All-Payer Primary Care Investment Target"** means the statewide financial target(s), as described in Section 10, which CMS will hold the State accountable for meeting on an annual basis to increase primary care spending as a percentage of the total cost of care ("TCOC"), across all payers in the State. The target(s) is inclusive of all expenditures for Medicare, Medicaid, and commercial insurance, including, but not limited to, employer-sponsored insurance, state employee health plans, and Marketplace plans, to the extent data are available.

b. "**All-Payer TCOC Growth Target**" means the numerical target(s), as described in Section 10, which CMS will hold the State accountable for meeting on an annual basis to limit spending across all payers for all residents in the State. The target is inclusive of all expenditures for Medicare, Medicaid, and commercial insurance, including, but not limited to, employer-sponsored insurance, state employee health plans, and Marketplace plans, to the extent data are available.

c. "**Annual Progress Report**" means the annual report submitted by the State to CMS in a form and manner specified by CMS, as described in Section 18.

d. "**CMS-Approved State-Designed Medicare FFS Hospital Global Budget Methodology**" means the methodology designed by the State and approved by CMS for use in calculating Medicare FFS Hospital Global Budgets for Participant Hospitals in the State.

e. "**Commercial Payer**" means health insurance plans holding a certificate of authority from Vermont's Commissioner of Financial Regulation. This term does not include coverage for accident or disability income insurance, liability insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site

medical clinics, or other similar insurance coverage if benefits for health services are secondary or incidental to other insurance benefits. This term includes Medicare Advantage plans, but does not include stand-alone dental or vision benefits; long-term care insurance; specific disease or other limited benefit coverage, Medicare supplemental health benefits, and other similar benefits.

f. "**Commercial Payer Hospital Global Budget**" means the prospectively set annual budget that is the basis for reimbursement in place of fee-for-service reimbursement for facility inpatient and outpatient services, at minimum, for Participant Hospitals pursuant to agreements that the Participant Hospitals enter into with the Commercial Payer.

g. "**Critical Access Hospital**" or "**CAH**" means a critical access hospital as defined in Section 1861(mm)(l) of the Act.

h. "**Eligible Hospital**" means an acute care hospital, Critical Access Hospital, or Rural Emergency Hospital that provides inpatient and/or outpatient services, is located in the State, and meets all eligibility criteria for participation in the AHEAD model.

i. "**Eligible Primary Care Practice**" means a primary care practice, Federally Qualified Health Center (FQHC), Health Center, Health Center Look-Alike, Rural Health Clinic (RHC), or practice with primary care specialties that is located in the State and meets all eligibility criteria for participation in the AHEAD model.

j. "**Enhanced Primary Care Payment**" or "**EPCP**" is a quarterly per-beneficiary payment to a Participant Primary Care Practice for an attributed Medicare beneficiary population.

k. "**Exogenous Factor**" means a factor outside the Parties' control, including factors unrelated to the Model (e.g., changes in health insurance coverage; the rapid adoption of a new technology; changes in law or regulations; localized health, environmental, or economic shocks; or localized civil disorder).

l. "**Federally Qualified Health Center**" **or** "**FQHC**" means a Federally qualified health center as defined in Section 1861(aa)(4) of the Act.

m. "**Health Center**" means a Health Resources and Services Administration (HRSA) designated and funded community-based and patient-directed organization that provides affordable, accessible, high-quality primary health care services to individuals and families, as further described in 42 U.S.C. § 254b.

n. "**Health Center Look-Alike**" means community-based health care providers that meet the requirements of the HRSA Health Center Program, but do not receive Health Center Program funding. They provide primary care services in underserved areas, provide care on a sliding fee scale based on ability to pay and operate under a governing board that includes patients as further described in 42 U.S.C. § 254b.

o. "**Health Oversight Agency**" means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant, as defined in 45 C.F.R. § 164.501.

p. "**Hospital Health Equity Plan**" means the health equity plan developed by a Participant Hospital in accordance with the requirements of the Participant Hospital's Participation Agreement and reviewed by the Model Governance Structure or other State-selected governing body.

q. "**Implementation Period**" means the period beginning on January 1, 2026, and ending on December 31, 2034, unless the Implementation Period is sooner terminated in accordance with Section 20, in which case the Implementation Period concludes on the effective date of such termination.

r. "**Medicaid Advanced Primary Care Program**" **or** "**Medicaid Advanced PCP**" means either a patient-centered medical home (PCMH) program or another primary care value-based payment arrangement that includes increased care transformation structure and accountability for enhanced care coordination, addressing health-related social needs, and mental health, substance abuse, and specialty integration, that aims to improve and advance coordinated, whole-person and team-based primary care for Medicaid beneficiaries.

s. **"Medicaid Hospital Global Budget"** means the prospectively set annual budget that is the basis for Medicaid reimbursement to Participant Hospitals for hospital services, calculated using a State-designed Medicaid hospital global budget methodology approved

by CMS and aligned with specifications included in AHEAD Cooperative Agreement Terms and Conditions.

t. "**Medicare FFS Beneficiary**" means an individual who is enrolled in Medicare Part A and/or B.

u. "**Medicare Fee-For-Service" or** "**Medicare FFS**" means Medicare Part A and Part B and does not include Medicare Part C (Medicare Advantage) or Medicare Part D.

v. "**Medicare FFS Hospital Global Budget**" means the prospectively set annual budget that is the basis for reimbursement to Participant Hospitals in place of Medicare Fee-For-Service reimbursement for facility inpatient and outpatient services, calculated using the CMS-Approved State-Designed Medicare FFS Global Budget Methodology.

w. "**Medicare FFS Hospital Net Patient Revenue**" **or "Medicare FFS NPR"** is defined as Medicare FFS claims and/or non-claims-based payments for inpatient and outpatient facility services delivered at Eligible Hospitals within the State. This excludes payments made Eligible Hospitals by beneficiaries (e.g., copays and deductibles) or by third party payers as approved by CMS for non-acute services and/or providers identified by the State as having an impact on acute care utilization in Vermont and aligned with the Statewide Accountability Targets, including but not limited to home health, skilled nursing, mental health, substance abuse, and specialty care services.

x. "**Medicare FFS Investment and Access Targets**" means the statewide spending targets as approved by CMS for non-acute services and/or providers identified by the State as having an impact on acute care utilization in Vermont and aligned with the Statewide Accountability Targets, including but not limited to, home health, skilled nursing, mental health, substance abuse, and specialty care services.

y. "**Medicare FFS TCOC Target**" is the per-beneficiary per-year (PBPY) Medicare FFS expenditure target calculated by CMS for each PY, as described in Appendix A.

z. **"Medicare FFS Primary Care Investment Target"** means the statewide financial target comprised of Medicare FFS primary care spending as a percentage of the total cost of care (TCOC) for Medicare FFS as set forth in Appendix B.

aa. "**Model Governance Structure**" means a multi-sector entity that may be convened by the State to provide input on Model activities as described in Section 9.

bb. "**Participation Agreement**" means the agreement entered into between the State, if applicable, CMS, and a Participant Hospital or Participant Primary Care Practice that sets forth the terms and conditions for participation in the Model.

cc. "**Participant Hospital**" means an Eligible Hospital that has executed a Participation Agreement with CMS and the State to participate in the Model.

dd. "**Participant Primary Care Practice**" means an Eligible Primary Care Practice that has executed a Participation Agreement with CMS to participate in the Model.

ee. "**Performance Year**" **or** "**PY**" means the period beginning on January 1 and concluding on December 31 of each year during the Implementation Period of the Model, as described in Section 1.d.

ff. "**Pre-Implementation Period**" means the period beginning on July 1, 2024 and ending on December 31, 2025.

gg. **"Primary Care AHEAD Payment Specifications"** means the final specification document that provides a detailed description of the financial methodology and payment features of Primary Care AHEAD.

hh. **"Proposed State-Designed Medicare FFS Hospital Global Budget Methodology"** means a proposed methodology designed by the State for use in calculating Medicare FFS Hospital Global Budgets for Participant Hospitals in the State, subject to CMS approval.

ii. "**Rural Emergency Hospital (REH)**" means a rural emergency hospital as defined in Section 1861(kkk)(2) of the Act and 42 C.F.R. § 419.91.

jj. "**Rural Health Clinic**" **or** "**RHC**" means a clinic that is located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases, and meets all other requirements specified in Section 1861(aa)(2) of the Act.

kk. "**Statewide Accountability Target**" means, collectively, the Medicare FFS TCOC Target, All-Payer TCOC Growth Target, the Medicare FFS Primary Care Investment Target, the All-Payer Primary Care Investment Targets, Medicare FFS Investment and Access Targets, and the Statewide Quality and Equity Targets as defined in Section 10 of the Agreement.

ll. "**Statewide Transformation Plan**" means the transformation plan developed by the State that describes the State's collective vision and strategy for transforming service delivery.

mm. "**Statewide Health Equity Plan or Statewide HEP**" means the health equity plan developed by the State, in collaboration with the Model Governance Structure or another State-selected governing body, that describes the State's collective vision and strategy for improving population health and advancing health equity.

nn. "**Transition Period**" means the period of up to 24 months, beginning upon the completion or termination of the Implementation Period of the Model.

oo. "**Underserved Communities,**" as defined by Executive Order 13985, means populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

3. CMS Legal Authority.

a. **General Authority to Test Model.** Section 1115A(b) of the Act authorizes the Innovation Center to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, or CHIP expenditures while maintaining or improving the quality of care for beneficiaries. Section 1115A(b)(2) of the Act requires the Secretary of Health and Human Services ("Secretary") to select models to be tested where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The statute provides a non-exhaustive list of examples of models that the Secretary may select including, "[a]llowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals."

b. **Waiver Authority.** Under Section 1115A(d)(1) of the Act, the Secretary may waive such requirements of Titles XI and XVIII and of Sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and 1934 (other than subsections (b)(1)(A) and (c)(5) of such section)

of the Act as may be necessary solely for purposes of carrying out Section 1115A with respect to testing models described in Section 1115A(b). CMS may withdraw or modify any waivers issued by CMS if the State does not comply with the terms and conditions set forth in this Agreement or with the terms and conditions of waivers as set forth in this Agreement or in separately issued documentation.

c. **Medicare Authority.** The Medicare portions of the Model must operate in a manner consistent with all applicable Medicare laws, rules, and regulations, as amended or modified from time to time, except to the extent these requirements are waived in accordance with Section 1115A(d)(1) of the Act as set forth in this Agreement or in separately issued documentation.

d. **Medicaid Authority.** The Medicaid portions of the Model must operate in a manner consistent with all applicable Medicaid laws, rules, and regulations, including but not limited to all requirements of the State's existing Medicaid state plan and any Section 1115(a) demonstration waivers, as amended or modified from time to time. The State must ensure that its Medicaid state plan and any Section 1115(a) demonstration waivers are updated to accommodate all changes in payment methodologies that the State implements pursuant to this Agreement.

e. **Model Participation Agreements.**

   i. CMS and the State will enter into Participation Agreements with Participant Hospitals.

   ii. CMS will enter into Participation Agreements with Participant Primary Care Practices.

4. State Legal Authority.

a. **Vermont Legal Authority.** The State represents and warrants that it has or shall obtain the legal authority under Titles 8, 18, and 33 of Vermont Statutes Annotated to: implement methodologies for payment reforms; set rates for providers; require commercial payers to comply with those rates; and perform the regulatory functions consistent with this Agreement. The State represents and warrants that the Model complies with state fraud and abuse laws or will propose changes to state laws that reflect the terms of this Agreement while providing adequate protection against fraud and abuse. The State further represents and warrants that it has the legal authority to enter into this

Agreement and shall comply with the applicable terms and conditions of this Agreement and all submissions related to the Model required pursuant to this Agreement.

b. **Vermont Medicaid Authority.** The State represents that AHS has the authority under a Section 1115 Medicaid waiver to operate Vermont Medicaid. AHS shall not withdraw or request modification of the Section 1115 Medicaid waiver in such a way as to limit its authority to participate in the Model. In addition, when AHS applies to CMS for a new waiver or a waiver renewal, the application to CMS shall request terms and conditions that are consistent with this Agreement. This Agreement does not limit or modify any rules and regulations or processes applicable to such approvals and as such, CMS intends to support consistency of any new Section 1115 Medicaid waiver or waiver renewal with this Agreement. Additionally, this Agreement does not abrogate the designation of AHS as the Single State Agency as required by 42 C.F.R. § 431.10 or otherwise alter AHS's responsibilities as the Single State Agency, to include its sole authority to set rates for Vermont Medicaid.

c. **Vermont Payment Authority.** The State also states that the GMCB has authority under 18 V.S.A. § 9375(b)(1)(A) to implement by rule methodologies for achieving payment reform and containing costs which may include the creation of global payments, global budgets, or other uniform payment methods and amounts for integrated delivery systems, health care professionals, or other provider arrangements, as well as authority under 18 V.S.A. § 9376 to set reasonable rates for health care professionals and others based on the methodologies adopted pursuant to 18 V.S.A. § 9375(b)(1)(A). The State further states that the GMCB has authority under 18 V.S.A. § 9375(b)(7) to review and establish hospital budgets consistent with the principles of health care reform in 18 V.S.A. § 9371, as required by 18 V.S.A. § 9375(a), and will review and establish hospital budgets in adherence to the requirements of18 V.S.A. § 9456.

5. Waivers and Safe Harbor Authority.

a. **Payment Waivers.**

i. Subject to the provisions of this Agreement, CMS will waive the requirements of the Act as listed in Appendix F of this Agreement solely, as necessary, for purposes of testing the Model.

ii. The State may request, and the Secretary may consider, additional Medicare payment waivers that may be necessary for the purposes of testing the Model. CMS may grant any Medicare payment waiver requested by the State at CMS' sole discretion. Such Medicare payment waiver, if any, would be set forth in separately issued documentation specific to this Agreement, an amendment to this Agreement, or pursued by CMS through rulemaking if necessary. Any such Medicare payment waiver(s) would apply solely to this Model and could differ in scope or design from waivers granted for other programs or models.

b. **Fraud and Abuse Waivers.** Financial arrangements between and among providers and suppliers must comply with all applicable laws and regulations, except as may be explicitly provided in a waiver issued specifically for AHEAD pursuant to Section 1115A(d)(1) of the Act. The Secretary may consider issuing one or more waivers of certain fraud and abuse provisions in Sections 1128A, 1128B, and 1877 of the Act ("**Fraud and Abuse Waiver**"), as may be necessary solely for purposes of carrying out this Model. Such Fraud and Abuse Waivers, if any, would be issued by CMS, the HHS Office of Inspector General, or both, and would be set forth in a separately issued document. Any such Fraud and Abuse Waiver would apply solely to this Model and could differ in scope or design from Fraud and Abuse Waivers granted for other programs or models. The Secretary may modify or revoke a Fraud and Abuse Waiver at any time and for any reason without the consent of the State.

c. **Federal Anti-kickback Statute Safe Harbor.** CMS may determine that the Federal Anti-kickback Statute safe harbor for CMS-sponsored model arrangements (42 C.F.R. § 1001.952(ii)(1)) and CMS-sponsored model patient incentives (42 C.F.R. § 1001.952(ii)(2)) is available to protect remuneration exchanged pursuant to certain financial arrangements or patient incentives permitted under applicable AHEAD Participation Agreements, provided that such arrangements and incentives comply with the requirements of the safe harbor and the requirements to be set forth in the applicable Participation Agreement. No such determination is being issued in this document. Such determination, if any, would be set forth in documentation separately issued by CMS. Once CMS has made such a determination, the Secretary may modify or revoke the

availability of the federal Anti-kickback Statute safe harbor at any time and for any reason without the consent of the State.

6. **State's Participation in other Medicare Programs, Models, or Demonstrations.**
   The State may simultaneously participate in AHEAD and other Medicare programs, models, or demonstrations in existence on the Effective Date.

7. **Cooperative Agreement.**
   a. The Parties acknowledge that prior to the Effective Date of this Agreement, the State entered into a Cooperative Agreement with CMS. Through the Cooperative Agreement, CMS makes funding available to the State to support the State's participation in the Model.
   b. The State's ability to receive this funding is subject to the State's ongoing compliance with the terms of this Agreement, the terms and conditions of the Cooperative Agreement award, and any other terms and conditions imposed by CMS.
   c. In the event of any inconsistency or conflict between the terms and provisions of this Agreement and the Cooperative Agreement, the terms and provisions of this Agreement shall control.

8. **General Model Participation Requirements.**
   a. **Medicare FFS Beneficiary Minimum.**
      i. If CMS determines, at any time during the Implementation Period, that the number of Medicare FFS Beneficiaries who reside within the State falls below 10,000, CMS will consider such determination to be a Triggering Event, as defined in Section 20.b.14.
   b. **Hospital Participation Requirements.**
      i. The State must ensure that at least 10 percent of the Medicare FFS Hospital Net Patient Revenue for Eligible Hospitals is under a Medicare FFS Hospital Global Budget for PY1.
      ii. The State must ensure that at least 50 percent of the Medicare FFS Hospital Net Patient Revenue for Eligible Hospitals is under a Medicare FFS Hospital Global Budget for PY2.

iii. The State must ensure that at least 80 percent of the Medicare FFS Hospital Net Patient Revenue for Eligible Hospitals is under a Medicare FFS Hospital Global Budget for PY3 and PY4.

iv. The State must ensure that at least 85 percent of the Medicare FFS Hospital Net Patient Revenue for Eligible Hospitals is under a Medicare FFS Hospital Global Budget for PY5 and each subsequent PY.

v. CMS, in a form and manner to be determined by CMS, will provide the Medicare FFS Hospital Net Patient Revenue calculations for a PY to the State by July 1st prior to the start of the applicable PY. CMS will calculate the Medicare FFS Hospital Net Patient Revenue for a PY based on Hospital Net Patient Revenue data from the calendar year two calendar years prior to the applicable PY, with 5 months of claims run out.

c. **Commercial Payer Requirements.**

i. The State shall use available legislative or regulatory authority to achieve commercial payer alignment with the Model.

ii. The State must establish a Commercial Payer Hospital Global Budget methodology no later than PY2 that aligns with the Hospital Global Budget Alignment Requirements for State-Designed Medicare FFS Hospital Global Budget Methodologies articulated in Appendix D for use in PY2, and maintain a Commercial Payer Hospital Global Budget methodology for each subsequent PY.

iii. The State must ensure that at least one Commercial Payer operating in the State offers a Commercial Payer Hospital Global Budget to Participant Hospitals by the start of PY2.

iv. No later than the end of PY1, the State must submit to CMS its plan to use available State legislative or regulatory authority to ensure Commercial Payer adoption of the Commercial Payer Hospital Global Budget methodology by PY3.

v. The State must use available State legislative or regulatory authority to ensure Commercial Payer adoption of the Commercial Payer Hospital Global Budget methodology by PY3.

vi. The State must provide a copy of any agreement, Memorandum of Understanding (MOU), or other legal instrument entered into between the State and a Commercial

Payer that effectuates the Commercial Payer Hospital Global Budgets to CMS no later than 90 days before the start of PY2.

d. **Medicaid Hospital Global Budget Requirements.**

i. The Parties acknowledge that the State submitted to CMS the State's methodology for Medicaid Hospital Global Budgets in accordance with the model milestones included in the Notice of Funding Opportunity Terms and Conditions.

ii. The State must pay Participant Hospitals under a Medicaid Hospital Global Budget for each PY of the Model.

iii. The State must notify CMS and receive approval from CMS prior to making any changes to the Medicaid Hospital Global Budget methodology.

e. Medicaid Advanced PCP.

i. The State must operate a Medicaid Advanced PCP during each PY.

ii. The Parties acknowledge that the State has implemented the Vermont Blueprint for Health, codified in Vermont statute as 18 V.S.A. Chapter 13, which meets the definition of Medicaid Advanced PCP.

9. Model Governance Structure.

a. **General**. The State acknowledges that it shall either form a Model Governance Structure or identify another State-selected governing body that will provide feedback and input, in accordance with this section, on the implementation of this Model. The State's formation of the Model Governance Structure or the identification of a State-selected governing body is not subject to CMS approval.

b. **Function.** The Model Governance Structure or another State-selected governing body must provide input to the State regarding the following Model implementation activities:

i. The selection of, and changes to, the Statewide Quality and Equity Targets, as described in Section 10;

ii. The development of the Statewide Health Equity Plan described and the production of the Annual Progress Report documenting the State's progress in implementing the Statewide Health Equity Plan, as described in Section 18.c.;

iii. The review of the Hospital Health Equity Plan described in Section 18.e.;

iv. Use of State planning funds on investments and other activities designed to meet the Model's quality and cost growth objectives described in Section 10.i.; and

v. Cooperative Agreement funding.

c. The State must describe the composition of the Model Governance Structure or State-selected governing body, as applicable, in the Statewide Health Equity Plan.

d. The State may report changes to the Model Governance Structure in an update to the Statewide Health Equity Plan or Annual Progress Report.

10. Statewide Accountability Targets.

a. **Medicare FFS TCOC Target.** For each PY, the State must limit Medicare FFS PBPY expenditures, as calculated by CMS following the methodology described in Appendix A, to less than or equal to the Medicare FFS TCOC Target for that PY.

i. By May 1 prior to the start of a PY, CMS will calculate a preliminary Medicare FFS TCOC Target for that PY, and by August 1 prior to the start of a PY, CMS will calculate the final Medicare FFS TCOC Target for that PY, based on the following Savings Component schedule and as outlined in Appendix A:

PY1	0.1%
PY2	0.1%
PY3	0.1%
PY4	0.1%
PY5	0.1%
PY6	0.1%
PY7	0.1%
PY8	0.1%
PY9	0.1%

ii. **Calculation Methodology.** For each PY, CMS will calculate State Medicare FFS PBPY expenditures to determine the State's performance on the Medicare FFS TCOC Target for that PY, by August 1 following the PY, in accordance with the methodology set forth in Appendix A.

iii. **Failure to Meet Targets.** If the State exceeds the Medicare FFS TCOC Target in any two PYs within a period of three consecutive PYs, CMS will issue a Warning Notice and may issue an Enforcement Action Notice, in a form and manner as described in Section 20. If CMS determines that the State's failure to meet the Medicare FFS TCOC Target is caused by Medicare FFS expenditures for services

delivered to Vermont Medicare FFS Beneficiaries in a location outside of the State ("**Medicare FFS Out of State Spending")**, CMS will not issue a Warning Notice or Enforcement Action.

iv. **Performing Better than Targets.** If the State limits Medicare FFS PBPY expenditures for a PY to $60 PBPY or more below the Medicare FFS TCOC Target for that PY, CMS may, at its sole discretion, offer the State an increased EPCP amount for Primary Care AHEAD for a subsequent PY. CMS, in a form and manner to be determined by CMS, will provide the State notice of CMS' offer to increase EPCP amount, the process to accept the offer, and the requirements the State must follow if the State accepts an increased EPCP amount, as described in Section 12.c, including but not limited to signing an amendment to this Agreement.

b. **All-Payer TCOC Growth Target.**

i. Prior to PY1, the State must establish the process to set the All-Payer TCOC Growth Targets through an executive order, legislation, or regulation.

ii. No later than ninety (90) days prior to the start of PY2, the State must provide to CMS the All-Payer TCOC Growth Targets for PYs 2 through 5, at minimum. The State must submit to CMS the All-Payer TCOC Growth Targets for each of PYs 6 through 9 no later than ninety (90) days prior to the start of the applicable PY.

iii. CMS may unilaterally amend the Agreement to reflect the All-Payer TCOC Growth Targets for PY2 and each subsequent PY at least sixty (60) days prior to the start of the applicable PY.

iv. For each of PYs 2 through 9, the State must limit the rate of growth for All-Payer TCOC, as calculated by the State and validated by CMS, in accordance with the State's All-Payer TCOC Growth Targets for that PY.

v. **Failure to Meet Targets.** If the State exceeds the All-Payer TCOC Growth Target for any two PYs within a period of three consecutive PYs, CMS will issue a Warning Notice and may issue an Enforcement Action Notice in a form and manner as described in Section 20. If CMS determines that the State's failure to meet the All-Payer Growth Target for a given PY is caused by all-payer expenditures for services delivered to Vermont residents in a location outside of

the State ("**All-Payer Out of State Spending")**, CMS will not issue a Warning Notice or Enforcement Action.

c. **Medicare FFS Primary Care Investment Target.**

i. The State must meet or exceed its annual Medicare FFS Primary Care Investment Target for each PY and Final Attainment Goal, as described in Appendix B.

ii. **Calculation Methodology.** CMS will calculate the State's performance on the Medicare FFS Primary Care Investment Target using the methodology described in Appendix B, by August 30 following each PY. CMS will include Community Health Team investments under the Blueprint for Health and Support and Services at Home (SASH) program expenditures for Medicare FFS Beneficiaries when calculating Medicare FFS primary care expenditures, as described in Appendix B.

iii. **Failure to Meet Targets.** If the State does not meet the Medicare FFS Primary Care Investment Target in any two PYs within a period of three consecutive PYs, CMS will issue a Warning Notice and may issue an Enforcement Action Notice, in a form and manner as described in Section 20.

d. **Medicare FFS Investment and Access Targets.**

i. By PY4, the State must establish Medicare FFS Investment and Access Targets aimed at achieving Statewide Accountability Targets through increasing investments in services and/or non-acute providers identified by the State as having an impact on acute care utilization in Vermont and aligned with the Statewide Accountability Targets, including but not limited to home health, skilled nursing, mental health, substance abuse, and specialty care services.

ii. By March 31, 2028, the State will submit its proposed Medicare FFS Investment and Access Targets to CMS in a Statewide Transformation Plan, as described in Section 18.d.

iii. CMS may unilaterally amend the Agreement to reflect the approved Medicare FFS Investment and Access Targets for PY4 and each subsequent PY at least sixty (60) days prior to the start of the applicable PY.

iv. **Failure to Meet Targets.** If the State does not meet the Medicare FFS Investment and Access Targets in any two PYs within a period of three consecutive PYs, CMS

will issue a Warning Notice and may issue an Enforcement Action Notice, in a form and manner as described in Section 20.

e. **All-Payer Primary Care Investment Target.**

i. Prior to PY 1, the State must establish the process to set the All-Payer Primary Care Investment Targets through an executive order, legislation, or regulation.

ii. No later than ninety (90) days prior to the start of PY2, the State must provide to CMS the All-Payer Primary Care Investment Target for each of PYs 2 through 5, at minimum. The State must submit to CMS the All-Payer Primary Care Investment Target for each of PYs 6 through 9 no later than ninety (90) days prior to the start of the applicable PY.

iii. In calculating whether the State has met the All-Payer Primary Care Investment Targets for an applicable PY, the State may include non-claims spending related to primary care, including, but not limited to, Community Health Team investments under the Blueprint for Health and SASH program expenditures.

iv. CMS may unilaterally amend the Agreement to reflect the All-Payer Primary Care Investment Targets for PY2 and each subsequent PY at least sixty (60) days prior to the start of the applicable PY.

vi. For each of PYs 2 through 9, the State must demonstrate increased all-payer primary care spending as a percentage of all-payer total cost of care, as calculated by the State and validated by CMS, in accordance with the State's All-Payer Primary Care Investment Target for that PY.

vii. **Failure to Meet Targets.** If the State does not meet the All-Payer Primary Care Investment Target in any two PYs within a period of three consecutive PYs, CMS will issue a Warning Notice and may issue an Enforcement Action Notice, in a form and manner as described in Section 20.

f. **Statewide Quality and Equity Targets**

i. The State shall, with CMS' approval, select, at minimum, five (5) statewide core and one (1) optional measure described in Appendix G, and set biannual interim and final quality and equity targets for each selected measure (collectively, the "**Statewide Quality and Equity Targets**").

ii. On or before May 1, 2025, the State may propose to CMS one or more measures that are not included in Table 1 or Table 2 of Appendix G as one of the State's selected measures for use in PY1. Each proposed measure that is intended to replace a core measure must be in the same domain as the measure that it is intended to replace. Each proposed measure that is intended to replace an optional measure must either be in one of the domains provided in Table 2 of Appendix G for optional measures, or the State may propose another domain aligned with the Statewide HEP. When proposing the measure to CMS, the State must provide a rationale to CMS that explains why the proposed measure better serves the goals of the Model compared to the measure or measures in Table 1 or Table 2 of Appendix G in the same domain. CMS will either approve or reject the proposed measure within 30 days of receipt of the State's proposal.

iii. No later than July 1, 2025, the Parties will document the Statewide Quality and Equity Targets in separately issued documentation entitled "Selected Statewide Quality and Equity Targets for the AHEAD Model".

iv. The State must measure and report to CMS on the State's performance on the interim and final Statewide Quality and Equity Targets in the Statewide Health Equity Plan as part of its Annual Progress Report for each PY of the Model, as outlined in Section 18.c.

v. The State is accountable for meeting the Statewide Quality and Equity Targets for PYs 2, 4, 6, and 8. The State is also accountable for ensuring that its performance on the selected statewide core and optional measures does not decline from one PY to another.

vi. The State, in collaboration with the Model Governance Structure or another State-selected governing body, may submit a request to CMS to change one or more of the selected core and optional measures as documented in the Selected Statewide Quality and Equity Targets for the AHEAD Model and/or the Statewide Quality and Equity Targets, and to propose to CMS one or more measures that are not listed in Appendix G.

    1. In the State's request, the State must address at least one of the following factors:

i. The alignment of the proposed measure with AHEAD quality goals and required quality domains in the Statewide HEP;
ii. Any variance from expected performance on the previously selected statewide core or optional measure described in Appendix G that prevents ascertainment of meaningful improvements;
iii. The availability of a more broadly applicable (across settings, populations, or conditions) measure for State health needs identified in the Statewide HEP; or
iv. The availability of another measure the State believes is more aligned with health needs identified in the Statewide HEP.

2. CMS may approve, reject, or request changes to any such request at its sole discretion.

vii. If CMS approves a State-requested change to the selected core and optional measures or the Statewide Quality and Equity Targets, the Parties will update the Selected Statewide Quality and Equity Targets for the AHEAD Model in advance of the PY in which the change would take effect.

viii. **Failure to Meet Targets.** If the State does not meet its Statewide Quality and Equity Targets for PY 2, 4, 6, or 8, and/or the State performance on the selected statewide core and optional measures declines from one PY to another, CMS will issue a Warning Notice and may issue an Enforcement Action Notice, in a form and manner as described in Section 20.

ix.

g. **Equity, Access, and Statewide Transformation Fund.** By the end of PY1, the State will establish, or will direct the establishment of, an Equity, Access and Statewide Transformation Fund ("**EAST Fund**") to support activities designed to increase investments in home health, skilled nursing, mental health, substance abuse, and specialty care services aligned with the Statewide Accountability Targets described in Section 10.

i. The 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.

ii. The State shall report on EAST Fund activities in the Statewide Transformation Plan, as described in Section 18.d.

iii. The EAST Fund shall not duplicate existing investments under the State's Global Commitment to Health Section 1115 Demonstration, as described in STC 11.1 of that Demonstration.

h. **Exogenous Factors.** CMS may adjust the calculation of a Statewide Accountability Target to take into account any Exogenous Factors.

i. The State may submit to CMS a written request, no later than six (6) months after the end of a given PY in which the State experienced an Exogenous Factor, requesting that CMS adjust a Statewide Accountability Target for that PY due to an Exogenous Factor.

ii. The State's request must include an explanation of the impact of the Exogenous Factor on the Model and a recommendation as to how CMS should adjust a Statewide Accountability Target due to the Exogenous Factor.

iii. CMS will approve or deny the State's request within 120 days of receipt of the request.

iv. Any adjustment to a Statewide Accountability Target due to an Exogenous Factor will be made by CMS at CMS' sole discretion. Such adjustments, if any, would be set forth in separately issued documentation specific to this Agreement and/or an amendment to this Agreement.

11. Medicare FFS Hospital Global Budgets.

a. General

i. The Parties acknowledge that this Model, including payment under the CMS-Approved State-Designed Medicare FFS Hospital Global Budget Methodology, is predicated on the Green Mountain Care Board's hospital budget review authority established in Vermont General Assembly 18 V.S.A. § 9375(b)(7), 18 V.S.A. § 9380, and the State's maintenance of all-payer hospital budget review.

ii. The Parties acknowledge that the State submitted its Proposed State-Designed Medicare FFS Hospital Global Budget Methodology to CMS for use in PY1 and subsequent PYs on July 8, 2024.

iii. If CMS does not approve a Proposed State-Designed Medicare FFS Hospital Global Budget Methodology, as revised in accordance with this section, by April 1, 2025, CMS will terminate the Agreement in accordance with Section 20.

iv. If CMS approves the State's Proposed State-Designed Medicare FFS Hospital Global Budget Methodology, as revised in accordance with this section, by April 1, 2025, CMS will pay the Medicare FFS Hospital Global Budget for each PY to each Participant Hospital, under terms of the CMS-Approved State-Designed Medicare FFS Hospital Global Budget Methodology.

b. Proposed State-Designed Medicare FFS Hospital Global Budget Methodology: CMS Review Process

i. After receipt of the State's Proposed State-Designed Medicare FFS Hospital Global Budget Methodology on July 8, 2024, CMS reviewed the Proposed State-Designed Medicare FFS Hospital Global Budget Methodology and provided the State a request for revision.

ii. The Parties have agreed that the State, pursuant to CMS' request for revision, must submit a revised Proposed State-Designed Medicare FFS Hospital Global Budget Methodology no later than January 31, 2025. The State may request to extend, by up to 14 days, the deadline for submission of the revised Proposed State-Designed Medicare FFS Hospital Global Budget Methodology, no later than January 21, 2025. CMS shall approve or deny any such extension within 10 days of receipt.

1. The State may include in its revised Proposed State-Designed Hospital Global Budget Methodology a Hospital Global Budget Operations Incentive (HGBOI) to incentivize early participation in hospital global budgets and enable investment in care management and care transformation needed to succeed under a hospital global budget.

    i. The HGBOI is an upward adjustment of no less than 2% and up to 3%. Participant Acute Care Hospitals are eligible for the HGBOI in PYs 1, 2, and 3; Participant Critical Access Hospitals that join before PY5 are eligible for the HGBOI for the first three years of participation. HGBOI payments will only be available to Participant Hospitals.

ii. Participant Hospitals that exit the model prior to PY6 will be required to repay to CMS any HGBOI payments.

iii. If CMS terminates the Model prior to PY6 pursuant to Section 20.h, Participant Hospitals will not be required to repay to CMS any HGBOI payments.

2. The State may include in its revised Proposed State Designed Hospital Global Budget Methodology additional adjustments related to the goals of this Model, subject to the requirements in Appendix D.
3. CMS will review the revised Proposed State-Designed Medicare FFS Hospital Global Budget Methodology and provide the State an approval, denial, or request for revision. CMS will aim to issue its decision within 30 days of receipt of the State's revised Proposed State-Designed Medicare FFS Hospital Global Budget Methodology.

iii. The Proposed State-Designed Medicare FFS Hospital Global Budget Methodology submitted by the State must include the following information:

1. The methodological specifications with which the State intends to calculate Medicare FFS Hospital Global Budgets for Participant Hospitals, including the level of detail necessary to allow CMS to replicate and validate such calculations;
2. A detailed description of the quality assurance plan the State will implement to ensure all Medicare FFS Hospital Global Budgets are calculated appropriately and in accordance with the methodology, if approved by CMS;
3. An explanation of how the Proposed State-Designed Medicare FFS Hospital Global Budget Methodology supports the Model's goals;
4. An explanation of how the Proposed State-Designed Medicare FFS Hospital Global Budget Methodology aligns with the CMS-Designed Medicare FFS Hospital Global Budget Methodology and with the Hospital Global Budget Alignment Requirements for State-Designed Methodologies articulated in Appendix D;
5. A process for the State to review a Participant Hospital's request for modification to the Participant Hospital's Medicare FFS Hospital Global Budget in connection with a planned service line adjustment (e.g., adjustments for service line additions

or removals), as described in Section 11.g, or a calculation error identified by the Participant Hospital;

6. The rationale for deviation from the CMS-Designed Medicare FFS Hospital Global Budget Methodology, if applicable;
7. An explanation of how the proposed methodology will enable the State to achieve Medicare FFS TCOC Targets as described in Section 10 and Appendix A; and
8. At least one sample calculation of a Medicare FFS Hospital Global Budget for an acute care hospital and one sample calculation for each other type of Eligible Hospital the State expects to participate in the Model in the upcoming Performance Year, as well as financial modeling estimating how Medicare FFS Hospital Global Budgets calculated using the proposed methodology would compare to what each hospital type would be paid for inpatient and outpatient facility services in the absence of the Model under a fee-for-service payment arrangement.

c. CMS Approved State-Designed Medicare FFS Hospital Global Budget Methodology: Modifications

i. The State may submit a written request to CMS to modify the CMS-Approved State-Designed Medicare FFS Hospital Global Budget Methodology. The request must include the State's proposed modifications and the rationale for each proposed modification. The proposed modifications must be aligned with the requirements of Section 11.b.iv of this Agreement.

ii. The State must submit the request for modification to CMS no later than 9 months prior to the start of the PY in which the State would like the modifications to take effect.

iii. Upon receipt, CMS will review the request and approve, deny, or request further review of the proposed changes. CMS will notify the State, in writing, of its decision within 60 days of its receipt of the State's request for modifications.

iv. If CMS determines it needs more than the 60 days to review the State's proposed modifications, it will provide written notification to the State of the need for additional time and will indicate in such written notification when it expects to complete its review.

v. CMS may, at any time, require the State to make modifications to its CMS-Approved State-Designed Medicare FFS Hospital Global Budget Methodology, and accompanying calculations, if CMS finds, in its sole discretion, that the State has not met Hospital Participation Requirements in Section 8.b or the methodology:

1. has unintended consequences for Medicare providers and Medicare FFS Beneficiaries;
2. is not providing Participant Hospitals with adequate resources;
3. is not facilitating savings to Medicare as intended; or
4. is otherwise not aligned with the Model's goals.

vi. CMS will consider the GMCB's annual hospital budget process timeline when determining the effective date for any modifications required by CMS under Section 11.c.v. of this Agreement and ensure that Participant Hospitals are given sufficient notice of any modifications.

d. CMS-Approved State-Designed Medicare FFS Hospital Global Budget Methodology, Process, and Payments

i. **CMS Calculation.** CMS will calculate the Medicare FFS Hospital Global Budget for each PY for each Participant Hospital using the CMS-Approved State-Designed Medicare FFS Hospital Global Budget Methodology, except as described in Section 11.d.ii.

1. CMS will share with the State an estimate of each Participant Hospital's Medicare FFS Hospital Global Budget for the upcoming PY, as calculated by CMS in accordance with the CMS-Approved State-Designed Medicare FFS Hospital Global Budget Methodology using the most recent data available, no later than 150 days prior to the start of the applicable PY.
2. CMS will share with the State each Participant Hospital's Medicare FFS Hospital Global Budget for the upcoming PY, as calculated by CMS in accordance with the CMS-Approved State-Designed Medicare FFS Hospital Global Budget Methodology, no later than 30 days prior to the start of the applicable PY.

ii. **State Calculation.** The State may calculate the Medicare FFS Hospital Global Budget for each Participant Hospital in a given PY if the State notifies CMS at least 365 days in advance of the applicable PY that it will do so.

1. The Parties acknowledge that as of January 1, 2025, CMS did not receive such notification from the State and CMS will calculate the Medicare FFS Hospital Global Budget for each Participant Hospital in PY1.
2. If the State submits such notification to CMS for PY2 or subsequent PYs, the State must submit to CMS each Participant Hospital's Medicare FFS Hospital Global Budget, as calculated by the State using the CMS-Approved State-Designed Medicare FFS Hospital Global Budget Methodology for the upcoming Performance Year, no later than 150 days prior to the start of that Performance Year.
3. Within 30 days of CMS' receipt of each Participant Hospital's Medicare FFS Global Budget as calculated by the State, CMS will review and validate each Participant Hospital's Medicare FFS Hospital Global Budget and notify the State of its decision to approve payment of the Medicare FFS Hospital Global Budget for a Participant Hospital as submitted or require revisions.
4. CMS may request additional information or data as needed to validate the State's calculations of any Participant Hospital's Medicare FFS Hospital Global Budget. If CMS identifies an error in the State's calculation of any Participant Hospital's Medicare FFS Hospital Global Budget, the State must correct any such errors at least 60 days prior to the start of the applicable PY.
5. If CMS does not approve a Participant Hospital's Medicare FFS Hospital Global Budget at least 60 days prior to the start of the applicable PY, CMS will calculate the Medicare FFS Hospital Global Budget for the Participant Hospital using the CMS-Approved State-Designed Medicare FFS Hospital Global Budget Methodology.
6. If after the start of a PY, the State wishes to update a Participant Hospital's Medicare FFS Hospital Global Budget for that PY, the State must submit a written request to CMS describing and providing its rationale for the requested update(s), as well as a proposed implementation timeline for each update.
7. CMS will notify the State of its decision to approve or deny the proposed update(s) in writing within 60 days of its receipt of the State's request. If

approved, CMS will indicate in its written correspondence when the approved updates are expected to be reflected in payments to the Participant Hospital.

iii. **Participant Hospital Request for Modification**

1. If a Participant Hospital requests modification to its Medicare FFS Hospital Global Budget for a PY, including, but not limited to, correcting a calculation error, the State must review and submit to CMS a recommendation to approve or deny the request for modification to the Participant Hospital's Medicare FFS Hospital Global Budget, along with all supporting data.
2. CMS will notify the State of its decision to approve or deny the request for modification. If approved, CMS will indicate in its written correspondence when the approved updates are expected to be reflected in payments to the Participant Hospital.
3. If CMS is unable to issue a decision on a request for modification to a Participant Hospital's Medicare FFS Hospital Global Budget for an upcoming year in time for the start of the applicable PY, the payment amount for the affected Participant Hospital(s) shall be carried over from the previous PY until CMS issues a decision, and the final payment for the applicable PY is determined.

e. **Medicare FFS Hospital Global Budget: Requirements for Participant Hospital Planned Service Line Adjustments.**

i. The State must review and analyze each Participant Hospital's request for a modification to the Participant Hospital's Medicare FFS Hospital Global Budget in connection with a planned service line adjustment and related supporting data (e.g., diagnosis-related groups (DRGs) or Healthcare Common Procedure Coding System (HCPCS) codes, revenue codes).

ii. The State must submit to CMS a recommendation to approve or deny a request for a modification to the Participant Hospital's Medicare FFS Hospital Global Budget in connection with a planned service line adjustment, along with all supporting data, no later than 120 days prior to the first PY for which the adjustment is requested.

1. If the Participant Hospital plans to add a service line, the State must make a recommendation to CMS based on the forecasted revenue from the added service line on whether to modify the Participant Hospital's Medicare FFS Hospital

Global Budget for the two PYs following the year of the planned service line adjustment, including supporting data.

2. If the Participant Hospital plans to remove a service line, the State must make a recommendation to CMS on whether to modify the Participant Hospital's Medicare FFS Hospital Global Budget to reflect any revenue associated with the contracted or eliminated services, including supporting data.

iii. When determining whether to approve or deny a Participant Hospital's request for a modification to the Participant Hospital's Medicare FFS Hospital Global Budget in connection with a planned service line adjustment, CMS will consider the following factors:

1. alignment with the Statewide Health Equity Plan and Statewide Accountability Targets;
2. the potential to achieve savings or budget neutrality for Medicare;
3. impact on beneficiary access to care; and
4. fulfillment of existing obligations under Medicare and Medicaid.

iv. If CMS approves a Participant Hospital's requested modification to the Participant Hospital's Medicare FFS Hospital Global Budget in connection with a planned service line adjustment, CMS will apply that modification to the Participant Hospital's Medicare FFS Hospital Global Budget starting in the following PY.

12. Primary Care AHEAD

a. CMS will operate Primary Care AHEAD beginning in PY1 for Eligible Primary Care Practices.

b. **CMS and State Responsibilities Under Primary Care AHEAD.**

i. The State must recruit primary care practices to participate in Primary Care AHEAD.

ii. Beginning for PY1 and each subsequent PY, the State must submit a list of primary care practices that may meet the eligibility criteria for participation in the AHEAD Model (**"Tentatively Eligible Primary Care Practices")** to CMS for CMS' consideration, no later than 120 days prior to the start of each PY.

iii. CMS will review the State's list of Tentatively Eligible Primary Care Practices to determine if the following eligibility criteria are met:

1. The practice is enrolled in Medicare;

2. The practice delivers primary care in the State;
3. The practice passes a Program Integrity Screening;
4. The practice will participate in the Medicaid Advanced PCP in the upcoming PY;
5. The practice is not participating in other models or demonstrations that prohibit concurrent participation in the Model; and
6. Except for FQHCs and RHCs, if the practice is owned by a health system, the health system hospital that serves the community in which the practice operates will participate in Hospital Global Budgets in the upcoming PY and each subsequent PY that the practice participates in Primary Care AHEAD..

iv. CMS will provide the State the list of approved Eligible Primary Care Practices at least sixty (60) days prior to each Performance Year. Following CMS' approval of Eligible Primary Care Practices for participation in Primary Care AHEAD, the State will coordinate with CMS on the execution of Primary Care AHEAD Participation Agreements with Participant Primary Care Practices.

v. **Care Transformation Requirements (CTRs).** The Parties acknowledge that the CTRs for practices participating in the State's Medicaid Advanced PCP, Blueprint for Health ("**Blueprint CTRs**"), align with the CTRs in Primary Care AHEAD.

1. To maintain alignment with the CTRs in Primary Care AHEAD, the State must ensure that the Blueprint CTRs remain focused on health-related social needs, care coordination, and mental health and substance use disorder integration in PY1 and each subsequent PY.
2. By PY4, Vermont will ensure the Blueprint CTRs align with the Medicare FFS Investment and Access Targets described in Section 10.d, , including, at minimum, activities related to specialist referrals and specialty care coordination and integration.
3. To the extent possible, reporting requirements included in the Participation Agreement for Participant Primary Care Practices will align with the practice and health service area reporting to the State under the State's Medicaid Advanced PCP.

4. The State must provide technical assistance to Participant Primary Care Practices to implement the CTRs in alignment with the State's Medicaid Advanced PCP.

vi. If CMS or the State terminates the Implementation Period pursuant to Section 20, the State must notify each Participant Primary Care Practice within thirty (30) days of the effective date of termination.

c. **Enhanced Primary Care Payment ("EPCP").** Beginning in the first quarter of PY1, CMS will pay Participant Primary Care Practices a prospective quarterly EPCP as described in the applicable Primary Care AHEAD Participation Agreement and the "**Primary Care AHEAD Payment Specifications**".

i. The value of the EPCP in PY1 will be a statewide average of $17 per beneficiary per month (PBPM), with a minimum of $15 and a maximum of $21. CMS will adjust the statewide average EPCP for inflation annually beginning in PY2 and each subsequent PY.

ii. In any given PY, CMS may further adjust the statewide average EPCP PBPM amount based on a range of factors including, but not limited to, the State's performance on the Medicare FFS TCOC Target in the previous PY and the State's ability to meet the hospital participation requirements as described in Section 8.b.

iii. CMS will adjust the EPCP amount paid to each Participant Primary Care Practice based on social and medical risk and the Participant Primary Care Practice's performance on select Primary Care AHEAD Quality Measures, as described in Section 12.e of this Agreement, and in accordance with the methodologies as described in the applicable Primary Care AHEAD Participation Agreement and the Primary Care AHEAD Payment Specifications document. CMS will calculate social and medical risk scores quarterly and quality performance scores annually.

iv. The methodologies used to calculate the EPCP are described in the Primary Care AHEAD Payment Specifications, which CMS will make available to the State. CMS may revise the Primary Care AHEAD Payment Specifications at CMS's sole discretion without the State's consent. To the extent practicable, CMS will provide the State and Participant Primary Care Practices with thirty (30) days advance

written notice of any such revisions to the Primary Care AHEAD Payment Specifications.

d. **Commercial Payer Alignment.** CMS will offer technical assistance to the State to facilitate Commercial Payer alignment with primary care transformation under AHEAD.

e. **Primary Care AHEAD Quality Measures.**

i. The State must select five (5) measures from the list of measures ("**Primary Care AHEAD Quality Measures**") as set forth in Appendix E, no later than forty-five (45) days after the Effective Date.

ii. Subject to CMS' approval, the State may propose alternative primary care measure(s) for implementation in PY1 and subsequent PYs.

1. The State must submit the proposed measure(s) for use in PY1 to CMS in writing with a justification explaining the rationale for the alternative measure(s), no later than 45 days after the Effective Date.
2. The State must submit the proposed measure(s) for use in PY2 and subsequent PYs to CMS in writing with a justification explaining the rationale for the alternative measure(s), no later than 365 days prior to the Performance Year for which the measure would take effect.
3. CMS may approve, reject, or request modifications to any such alternative measure(s) at its sole discretion.

iii. Subject to CMS' approval, the State may request to change one or more of the five (5) Primary Care AHEAD Quality Measures selected for PY1 to a different measure listed in Appendix E for implementation in PY1 and subsequent Performance Years.

1. The State must submit the proposed measure(s) to CMS in writing with a justification explaining the rationale for the alternative measure(s), no later than 365 days prior to the PY for which the measure would take effect.
2. CMS may approve, reject, or request modifications to, any such requested measure change at its sole discretion.

13. Quality Payment Program.

a. In a form and manner to be determined by CMS, CMS will determine the Advanced Alternative Payment Model (AAPM) status for the CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology prior to PY1.

b. CMS will be available to provide technical assistance to Vermont and Vermont provider on their AAPM status.

14. Medicare Beneficiary Protections.

a. The State and CMS must ensure that Medicare beneficiaries' access to items, services, providers, and suppliers will not be limited by the implementation of the Model.

b. Specifically, the State and CMS will ensure that the State's Medicare beneficiaries will: (1) retain full freedom of choice of providers and suppliers, as well as all rights and beneficiary protections otherwise available under the Medicare program, and (2) retain coverage of the same items and services otherwise covered under Medicare FFS.

c. The State's Medicare FFS beneficiaries must not experience any reductions in their rights to benefits or covered services under this Agreement.

15. Data Sharing.

a. **Health Oversight Agency.** The State represents that it is a Health Oversight Agency and includes assertions in Appendix H and Appendix I from the GMCB and AHS as to their status as a "Health oversight agency" (as that term is defined in 45 C.F.R. § 164.501) in the context of this Model. The State must maintain its status as a Health Oversight Agency throughout the Implementation Period. If the State loses its status as a Health Oversight Agency, CMS will consider this to be a Triggering Event subject to an enforcement action, as described in Section 20, and CMS will no longer share Medicare FFS Beneficiary data with the State.

b. **CMS Data Sharing.**

   i. During the Agreement Term, CMS will offer the State an opportunity to request certain Medicare data and reports using a data request process to be determined in a form, manner, and time by CMS. All such requests for beneficiary-identifiable information must clearly state which provision under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule permits the

requested disclosure (e.g., for health oversight activities under 45 C.F.R. § 164.512(d)). The State will ensure that each request for data is limited to the minimum data necessary to accomplish the task. CMS will provide this Medicare data to the State in a manner consistent with all applicable laws and regulations, including HIPAA. CMS will make best efforts to approve, deny, or request additional information within 30 days of receipt. CMS will accept or reject such requests on a case-by-case basis and at CMS' sole discretion.

ii. Medicare data requests may include information that has been de-identified in accordance with the HIPAA Privacy Rule requirements in 45 C.F.R. § 164.514(b). Such Medicare data may also include certain beneficiary-identifiable Medicare eligibility status and demographic information of all Medicare FFS beneficiaries residing in the State and claim line data for items and services furnished to those beneficiaries. CMS may provide additional reports that include the following: utilization, expenditures, quality of care, Medicare eligibility type, and performance summary comparisons to other states.

c. **State Use and Disclosure of CMS Data.**

i. The State is expected to use the requested data in its efforts to monitor and oversee the State's health care system as it pertains to this Agreement. Notwithstanding any other provision of this Agreement, and in accordance with applicable law, the State may disclose original or derivative beneficiary-identifiable data received under this Agreement to Model participants. Such disclosures may be made without prior authorization from CMS if such disclosure is necessary to enable the State's oversight of the Model, or to enable quality improvement activities or health care provider incentive implementation.

ii. Notwithstanding any other provision of this Agreement, the State may use the data received from CMS under this Agreement to create "de-identified" data as that term is understood under the HIPAA Privacy Rule at 45 C.F.R. § 164.514(b), and may share such de-identified data as is necessary to enable the State's oversight of the Model, or to enable quality improvement activities or health care provider incentive implementation.

iii. The State must use appropriate privacy and security protections for any data used and disclosed under this Model, in accordance with applicable law and CMS policies. In the event that the State discovers any use, reuse, or disclosure of the data received from CMS that violates this Agreement, it must report the incident or breach via email to both the CMS IT Service Desk and the CMS DUA Mailbox within one hour of discovery and fully cooperate in the federal security incident response.

d. **State Data Reporting Requirements.**

i. In accordance with 42 C.F.R. § 403.1110(b), the State must collect and report to CMS all-payer health care spending and population health outcome data, all-payer primary care spending data, and access and quality metric data on an annual basis that is necessary to support CMS monitoring and evaluation of the Model. The State must retain such documentation in accordance with Section 23.

ii. The State must submit to CMS certain Medicaid and commercial plan claims data from Commercial Payers operating in the State to support CMS monitoring and evaluation of the Model, as specified by CMS and to the extent allowed by law. The State may provide these data from a combination of sources, including State data systems, Medicaid plans, or commercial plans. The State will provide all information to CMS in a manner consistent with all applicable laws and regulations, including, but not limited to, HIPAA and its implementing regulations.

iii. CMS may use the data it receives from the State to conduct analyses and may publish data and analyses that have been de-identified in accordance with 45 C.F.R § 164.514(b).

e. **Commercial Payer Data Sharing.** During the Implementation Period of the Model, to the extent allowable by law, the State must establish data use agreements with each Commercial Payer operating in the State to acquire data needed to calculate the Statewide All-Payer TCOC Growth Target, All-Payer Primary Care Investment Targets, and set appropriate hospital global budgets for the Participant Hospitals. The specific terms of this data sharing will be set by the data use agreements between the State and the State's Commercial Payers.

f. **Primary Care Spending Data Sharing**.

i. The State must provide to CMS all-payer primary care spending data for monitoring, evaluation, and calculation of All-Payer Primary Care Investment Targets no later than 15 months after the end of each PY. To the extent allowable by law, these data must include primary care spending of all commercial and Medicaid payers, including, but not limited to, Medicare Advantage plans, State Medicaid spending, and state employee health plans.

ii. CMS will supply a non-claims-based-payment reporting template to the State by 180 days prior to the first PY and will update this template yearly within 180 days of the start of each PY.

iii. The State must use the non-claims-based-payment reporting template to collect and share with CMS any all-payer primary care spending that is not captured by claims.

16. Confidentiality.

a. The State must develop and implement procedures to protect the confidentiality of all information that identifies individual Medicare, Medicaid, and CHIP beneficiaries in accordance with all applicable laws.

17. Monitoring.

a. **CMS Monitoring of the Model.** CMS will conduct monitoring activities to assess the State's compliance with the terms of this Agreement.

i. CMS' monitoring activities will include, but are not limited to:

1. Interviews with practitioners participating in the Model and any members (including any contractors) of the State involved in operating the Model;
2. Interviews with beneficiaries and their caregivers;
3. Audits of regulatory actions taken by the State, implementation plans, calculations of Participant Hospitals' Medicare FFS Hospital Global Budgets, and other data from the State;
4. Audits of claims-level utilization and quality data from Model participants and non-participants;
5. Audits of program integrity screening data collected from Model participants;
6. Site visits to Participant Hospitals, Participant Primary Care Practices, the State, and community stakeholders; and

7. Requests for documentation of regulatory or operational activities sent to the State.

ii. CMS will, to the extent practicable, provide the State with a schedule of planned comprehensive annual audits to be conducted for purposes of monitoring the Model.

1. Such schedule does not preclude the ability of CMS to conduct more limited, targeted, or ad hoc audits, as necessary.
2. CMS may alter such schedule without the consent of the State. To the extent practicable, CMS will notify the State within 15 days of altering such schedule, and will take into consideration the schedule of the State's staff, and CMS will attempt to reschedule announced audits at a mutually agreeable time.

iii. The State will monitor performance on addressing any identified disparities over the Agreement Term.

iv. The State must cooperate with all CMS monitoring and oversight requests and activities, in accordance with 42 C.F.R. § 403.1110.

v. The State must submit reports to CMS in accordance with the requirements of Section 18 of this Agreement. The State must make available to CMS and CMS' designee(s) any data required for monitoring and assessment, including, but not limited to, such data as may be required for validation and oversight purposes, the State's datasets and methodologies used for preparing these and any other reports provided by the State to CMS, including, as applicable, access to contractors, contract deliverables, and software systems used to make calculations required under the Agreement.

b. **State Monitoring of the Model.**

i. By PY1, the State must establish procedures to monitor Participant Hospitals and Participant Primary Care Practices for fraud and any adverse impacts on Medicare, Medicaid, and CHIP beneficiary access to care .

ii. The State must notify CMS in writing of any issues discovered as a result the State's monitoring activities no later than 30 days after identification.

18. Reporting.

a. **Annual Progress Report:** The State must submit to CMS an Annual Progress Report by March 31 of each PY, and by March 31 following the end of PY 9, as described in this Section 18, providing updates on the State's performance and activities from the preceding PY, using the most recent data available.

   i. For Annual Progress Report II due on March 31, 2026, the State must provide updates on the State's performance and activities that occurred during the Pre-Implementation Period.

b. Each Annual Progress Report must at a minimum include the following information:

   i. Updates regarding the State's performance on Statewide Accountability Targets;

   ii. Updates regarding the State's efforts to recruit hospitals and primary care practices to participate in AHEAD;

   iii. Updates to the Blueprint CTRs;

   iv. Updates regarding the State's efforts to recruit Commercial Payers to Primary Care AHEAD and to offer Commercial Payer Hospital Global Budgets, including breakdowns by Commercial Payer;

   v. Updates regarding the funding sources of the EAST Fund and the use of the funds for activities in support of the Statewide Accountability Targets;

   vi. Narrative regarding updates in the Statewide Health Equity Plan and Participant Hospitals' Health Equity Plans, including:

      1. The State's progress towards the State's population health goals and strategies;
      2. Updates regarding biannual interim and final quality and equity targets for each selected measure linked to population health goals;
      3. Any identified challenges or barriers to the Statewide Health Equity Plan strategies and the established resolution; and
      4. Any other relevant updates associated with the State's health equity efforts and population health improvements in the Model.

   vii. If applicable, any memoranda from the State proposing a change to the Statewide Quality and Equity Targets, including the statewide core measures, or the Primary Care AHEAD Quality Measures.

c. Statewide Health Equity Plan

i. The State must update the Statewide Health Equity Plan as part of its Annual Progress Report submission, beginning with Annual Progress Report II due March 31, 2026.

ii. Beginning with Annual Progress Report III due March 31, 2027 and each Annual Progress Report thereafter, the State must submit the most recent performance data available on Statewide Quality and Equity Targets.

d. Statewide Transformation Plan

i. Beginning with Progress Report IV due on March 31, 2028, the State must submit a Statewide Transformation Plan for CMS approval in a form and manner specified by CMS. This plan must describe the State's vision for statewide health delivery system transformation and include the State's proposed Medicare FFS Investment and Access Targets as described in Section 10.d. and the proposed methodology for how performance on these targets will be calculated.

ii. Upon receipt, CMS will review the Statewide Transformation Plan and approve, deny, or request modification within 90 days.

iii. The State must update the Statewide Transformation Plan, including the State's performance on the Medicare FFS Investment and Access Targets and related efforts supporting the achievement of these targets as part of its Annual Progress Report submission, in each subsequent Annual Progress Report.

e. **Hospital Health Equity Plan.** The State must collect and review the Participant Hospitals' Hospital Health Equity Plans utilizing guidance provided by CMS. The State may choose to collaborate with the Model Governance Structure or another State-selected governing body in collecting and reviewing the Participant Hospitals' Hospital Health Equity Plans. The State must collect updates made to the Hospital Health Equity Plans and include those updates in the Annual Progress Report.

f. The State must ensure that any activities, goals, or actions described in the Hospital Health Equity Plan or otherwise connected to the Model do not discriminate against any individual on the basis of race, ethnicity, national origin, religion, sex, sexual orientation, disability, or gender.

g. The State may request an extension to reporting deadlines specified in this Section 18, for all or part of the information required, which CMS may approve or reject. The State must submit its request for an extension at least thirty (30) days before the applicable reporting deadline.

19. Model Evaluation.

a. **CMS Evaluation.**

i. CMS will evaluate the Model in accordance with Section 1115A(b)(4) of the Act.

ii. The State must cooperate with CMS and/or CMS' designee(s) and provide all data that the State is required to provide under the provisions of Section 15 of this Agreement or that CMS may request from the State to evaluate and monitor the Model in accordance with applicable law and this Agreement. Such data may include, but would not be limited to, beneficiary identifiable information that is needed to carry out CMS' evaluation and monitoring of this Model and the terms of any arrangements related to rate- or budget-setting or payment entered into between the State, Participant Hospitals, and Participant Primary Care Practices prior to or during the Model.

iii. The State must ensure that all necessary written agreements and/or legal relationships have been secured with any relevant entities, agents, or partners and include terms expressly identifying the means by which CMS and CMS' designee(s) are entitled to access individually identifiable data to carry out evaluation and monitoring activities. *See* 42 C.F.R. § 403.1110(b).

iv. CMS will share Model data, documents, and other information with its designees for evaluation, monitoring, oversight, and other purposes, in accordance with applicable law. CMS will use any data obtained pursuant to the Model to publicly disseminate de-identified quantitative and qualitative results, in accordance with applicable law.

20. Enforcement Action and Termination.

a. **Grounds for Enforcement Action**. CMS may take an enforcement action against the State if CMS determines a Triggering Event has occurred.

b. **Triggering Event**. A Triggering event includes the following:

1. A determination by CMS that the Model has had one or more of the following effects not otherwise enumerated as a Triggering Event: negative consequences for Medicare providers and Medicare FFS Beneficiaries; State not providing Model participants with adequate resources; State is not facilitating savings or improving quality as intended; or effects of the model are otherwise not aligned with the Model's goals or the State's methodology.
2. A determination by CMS that the State has failed to meet the Statewide Quality and Equity Targets for PYs 2, 4, 6, or 8.
3. A determination by CMS that the State has failed to meet the All-Payer TCOC Growth Target in any two PYs within a period of three consecutive PYs.
4. A determination by CMS that the State has failed to meet the All-Payer Primary Care Investment Targets in any two PYs within a period of three consecutive PYs.
5. A determination by CMS that the State has failed to operate a Medicaid Advanced PCP starting in PY1 and each PY of the Model thereafter.
6. A determination by CMS that the State failed to ensure Participant Primary Care Practices participate in the Medicaid Advanced PCP during PY1 and each PY thereafter.
7. A determination by CMS that the State has failed to implement the Medicaid Hospital Global Budget prior to the end of PY1 or for any subsequent PYs.
8. A determination by CMS that the State has not established All-Payer TCOC Growth Targets for PYs 2 through 5, at a minimum, by PY2.
9. A determination by CMS that the State has not established All-Payer Primary Care Investment Targets for PYs 2 through 5, at a minimum, by PY 2.
10. A determination by CMS that the State has failed to meet the Medicare FFS Primary Care Investment Target in any two PYs within a period of three consecutive PYs.
11. A determination by CMS that the State has failed to meet the Medicare FFS TCOC Target in any two PYs within a period of three consecutive PYs

12. A determination by CMS that the State is materially noncompliant with the terms and conditions of the Cooperative Agreement or fails to meet the Model milestones within the Cooperative Agreement.
13. CMS' termination of the State's Cooperative Agreement.
14. A determination by CMS that the number of Medicare FFS Beneficiaries residing within the State has fallen below 10,000.
15. A determination by CMS that the State has failed to materially comply with the requirements of this Agreement.
16. A determination by CMS that less than 80% of Medicare FFS NPR would be under Medicare FFS Hospital Global Budgets by PY3.
17. A determination by CMS that less than 85% of Medicare FFS NPR would be under Medicare FFS Hospital Global Budgets by PY5 or any subsequent PY.
18. If the State fails ensure at least one Commercial Payer operating in the State offers a Commercial Payer Hospital Global Budget to Participant Hospitals by the start of PY2.
19. A determination by CMS that the State has taken any action that threatens the health or safety of a Medicare FFS Beneficiary or other patient.
20. A determination by CMS that the State has taken actions that compromise the integrity of the Model or the Medicare Trust Funds.
21. The State fails to maintain its status as a Health Oversight Agency as described in Section 15.a.
22. A determination by CMS that the quality of care provided to Medicare, Medicaid, or CHIP beneficiaries has deteriorated at any point in time throughout the Model.
23. If the State submits false data or makes false representations, warranties, or certifications in connection with any aspect of the Model.
24. If the State enacts legislation, implements regulation, or takes any other action that inhibits the ability of the State and/or its payers to participate in the Model, and CMS determines that such changes and/or actions are not consistent with the requirements of this Agreement.

c. **Triggering Event Factors.**

i. CMS may take into account the totality of the circumstances when determining if a Triggering Event occurred.

ii. The State may demonstrate, in accordance with the process described in Section 20.e, 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.

d. **Changes to Payments.**

i. CMS may adjust Medicare FFS payments under the Model to Participant Hospitals via the CMS-Approved State-Designed Medicare FFS Hospital Global Budget Methodology and/or the EPCP made to the Participant Primary Care Practices if the following determination or request occurs:

1. If CMS determines a Triggering Event has occurred and the adjustment is intended to correct the Triggering Event; or
2. If the State requests an adjustment to one or more payments described in Section 20.d.i before CMS has determined a Triggering Event has occurred and the adjustment is intended to result in performance that avoids a Triggering Event.

e. **Warning Notice.**

i. 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.

ii. Unless otherwise specified in this Agreement or as stated by CMS in the Warning Notice, within 30 days of receipt of the Warning Notice, the State must submit a written response to CMS that sufficiently responds to each of CMS' questions and any document requests outlined in the Warning Notice.

iii. Unless otherwise specified in this Agreement or as stated by CMS in the Warning Notice, CMS will accept the State's response to the Warning Notice as sufficient or CMS will not accept the State's response to the Warning Notice as sufficient.

f. **Enforcement Action Notice.** 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. CMS may take one or more of the following enforcement actions:

i. Require the State to submit and implement a corrective action plan (CAP) in accordance with Section 20.g;
ii. Require the State, if applicable, to modify its CMS-Approved State-Designed Medicare FFS Hospital Global Budget Methodology, as described in Section 11;
iii. Require the State to provide additional information to CMS;
iv. Subject the State to additional monitoring, auditing, or both;
v. Require the State to propose to CMS for approval new safeguards or programmatic features to be added to the Model;
vi. 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;
vii. Modify or terminate a Medicare payment waiver or waivers identified in paragraphs 3 through 12 of the list of "Medicare Payment Waivers" or the list of "Benefit Enhancements" in Appendix F of this Agreement.

g. Corrective Action Plan.

i. The State must submit a CAP to CMS within 45 days of receipt of an Enforcement Action Notice requiring a CAP. The CAP must describe actions the State and, if applicable, other participants in the Model, will take, including any specific corrective actions detailed by CMS in the Enforcement Action Notice, within the time period specified in the Enforcement Action Notice, to ensure any deficiencies will be corrected and that the State, and other participants in the Model if applicable, will be in compliance with the terms of this Agreement.
ii. The Enforcement Action Notice will provide a specified period of time the State has to implement the terms of the CAP.
iii. CMS will review and approve, or require modifications to, the proposed CAP within 45 days of receipt.
iv. The CMS-approved CAP will provide the State the criteria, timeframe, and a process for successful completion of the CAP.

v. If CMS determines the State has failed to submit, obtain approval for, implement successfully, or fully comply with the terms of a CAP required by Section 20.g. and the CAP was required due to a Triggering Event listed in 20.b.7. through 20.b.24., CMS may take one or more of the following actions:

1. Modify or terminate Medicare payment waiver or waivers identified paragraphs 1 and/or 2 of the list of "Medicare Payment Waivers" in Appendix E of this Agreement.
2. Take additional enforcement actions described in Section 20.f.
3. Terminate any Participation Agreement related to the Model;
4. Terminate the Pre-Implementation Period or the Implementation Period of the Model; or
5. Terminate this Agreement.

h. **Termination by CMS.**

i. CMS may immediately or with advance notice terminate the Model, a Participation Agreement, the Implementation Period and/or Transition Period of the Model, or this Agreement if CMS, in its sole discretion, determines that:

1. the State has failed to submit, obtain approval for, successfully implement, or fully comply with the terms of a CAP required by Section 20.g. and the CAP was required due to a triggering event listed in Section 20.b.7. through 20.b.24; or
2. the State has not timely complied with an enforcement action required by CMS pursuant to Section 20.f.ii. through 20.f.v., provided such enforcement action was due to a triggering event listed in event listed in Section 20.b.7. through 20.b.26; or

ii. CMS will immediately terminate this Agreement and/or the Pre-Implementation Period of the Model if the State has failed to receive approval by CMS for a Proposed State-Designed Medicare FFS Hospital Global Budget Methodology by April 1, 2025, as described in Section 11.a.iii.

i. **Termination by the State.** The State may terminate the Implementation Period of the Model at any time for any reason upon 180 days advance written notice to CMS. The

State may terminate the Pre-Implementation Period at any time for any reason upon 30 days advance written notice to CMS.

j. **Termination under Section 1115A(b)(3)(B).** CMS may immediately terminate the Implementation Period, the Transition Period, or this Agreement if the Secretary makes findings under Section 1115A(b)(3)(B) of the Act.

21. Limitations on Review and Dispute Resolution.

a. **Limitation on Review.** There is no administrative and judicial review under Sections 1869 and 1878 of the Act or otherwise for the following:

i. The selection of states, organizations, sites, or participants in the Model, including the decision by CMS to terminate this Agreement or to require the termination of any individual's or entity's status or participation in the Model;

ii. The selection of models for testing or expansion under Sections 1115A of the Act;

iii. The elements, parameters, scope, and duration of the Model, including methodologies and calculations developed under the Model, as discussed herein, and the Cooperative Agreement;

iv. The termination or modification of the design and implementation of the Model under Section 1115A(b)(3)(B) of the Act;

v. Determinations regarding budget neutrality under Section 1115A(b)(3) of the Act; and

vi. Determinations about expansion of the duration and scope of a model under Section 1115A(c) of the Act.

b. **Dispute Resolution**.

i. The Parties agree to the following procedures for any dispute that is not subject to preclusion of administrative or judicial review as set forth in Section 21.a. or any dispute related to CMS-Approved State-Designed Medicare FFS Hospital Global Budget Methodology requirements or calculations.

ii. The State must notify CMS of any such dispute in writing within 30 calendar days of the date on which the State becomes aware, or should have become aware, of the act giving rise to the dispute. This written notification must provide a detailed explanation of the basis for the dispute and supporting documentation.

iii. If the Parties cannot resolve any such dispute within 30 calendar days after CMS receives written notice of the dispute, then the State must submit within 30

subsequent calendar days a request for an informal hearing to an independent CMS hearing officer, or an independent CMS designee, including the detailed explanation of the basis for the dispute and supporting documentation.

iv. After receiving the State's request for an informal hearing, the independent CMS hearing officer must issue a notice within 30 calendar days to the State and CMS for a hearing scheduled no fewer than 30 calendar days after the date of the notice. This notice will specify the date, time and location of the hearing, and the issues in dispute.

v. Within 30 calendar days of the hearing, the independent CMS hearing officer must issue a written notice to the State containing its final determination on the issue, and announcing the effective date of the determination, if applicable.

vi. The State may request the CMS Administrator's review of the independent CMS hearing officer's determination within 30 days of the issuance of the written notification of the independent CMS hearing officer's determination. If the CMS Administrator declines to review or is not requested to review the independent CMS hearing officer's determination, the independent CMS hearing officer's determination becomes final and binding 30 days after the issuance of the written notification of the independent CMS hearing officer's determination. The CMS Administrator's decision is final and binding.

vii. The parties must proceed diligently with the performance of this Agreement during the course of any dispute arising under this Agreement.

22. Federal Government Enforcement

a. Nothing contained in this Agreement is intended or shall be construed as a waiver by the United States Department of Justice, the Internal Revenue Service, the Federal Trade Commission, HHS Office of Inspector General (OIG), or CMS of any right to institute any proceeding or action for violations of any statutes, rules or regulations administered by the Federal government, or to prevent or limit the rights of the Federal government to obtain relief under any other federal statute or regulations, or on account of any violation of this Agreement or any other provision of law.

b. This Agreement shall not be construed to bind any Federal government agency except CMS, and this Agreement binds CMS only to the extent provided herein. The failure by

CMS to require performance of any provision shall not affect CMS' right to require performance at any time thereafter, nor shall a waiver of any breach or default of this Agreement constitute a waiver of any subsequent breach or default or a waiver of the provision itself. None of the provisions of this Agreement limit or restrict the OIG's authority to audit, evaluate, investigate, or inspect the State, hospitals or providers and/or suppliers in the State, or individuals or entities performing functions or services related to activities under this Agreement.

c. CMS provides no opinion on the legality of any contractual or financial arrangement that the State has proposed, implemented or documented. The receipt by CMS of any such documents in the course of the application process or otherwise shall not be construed as a waiver or a modification of any applicable laws, rules, or regulations and will not preclude CMS, HHS, or the OIG, a law enforcement agency, or any other federal agency or state agency from enforcing any and all applicable laws, rules and regulations.

23. Maintenance of Records.

a. In accordance with applicable law, the State must maintain and give CMS and other applicable HHS agencies, the Department of Justice, the Government Accountability Office, and other federal agencies or their designees access to all books, contracts, records, documents, software system, and other information (including data related to calculations required under the Model Agreement, Medicare utilization and costs, quality performance measures, and financial arrangements) sufficient to enable the audit, evaluation, inspection, or investigation of the State's compliance with the requirements of this Agreement.

b. The State must maintain such books, contracts, records, documents, and other information for a period of 10 years after the final date of the Agreement Term or from the date of completion of any audit, evaluation, inspection or investigation, whichever is later, unless: (1) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the State at least 30 days before the normal disposition date; or (2) there has been a termination, dispute, or allegation of fraud or similar fault against the State, Participant Hospitals, Participant Primary Care Practices, or other individuals or entities performing functions or services related to the Model, in which case the records must be maintained for an additional six (6) years from

the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault.

24. Survival.

a. Termination of the Agreement or expiration of the Agreement Term shall not affect the rights and obligations of the Parties accrued prior to the effective date of the termination or expiration of the Agreement or Agreement Term, except as provided in this Agreement.
b. The rights and duties under the following sections of this Agreement must survive its termination or expiration and apply for a period of three (3) years from the termination or expiration of this Agreement:
    i. Section 17 (Monitoring); and
    ii. Section 19 (Model Evaluation).
c. The rights and duties under the following sections must survive the termination of the Agreement or expiration of the Agreement Term and apply for a period of ten (10) years from the termination or expiration of this Agreement:
    i. Section 15 (Data Sharing); and
    ii. Section 23 (Maintenance of Records).

25. Third Party Beneficiaries.

This Agreement is not intended to, and does not, create any rights, benefits, or interest in any third-party person or organization.

26. Severability.

In the event that any one or more of the provisions of this Agreement is, for any reason, held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality or unenforceability must not affect any other provisions of this Agreement, and this Agreement must be construed as if such invalid, illegal or unenforceable provision or provisions had never been included in the Agreement, unless the deletion of such provision or provisions would result in such a material change to the Agreement so as to cause continued participation under the terms of the Agreement to be unreasonable.

27. Notice.

All notices, requests, and correspondence required or permitted by this Agreement must be in writing and sent to the below email addresses and, if requested, mailing addresses:

To the State:

Office of the Secretary
Jenney.Samuelson@vermont.gov or successor
Vermont Agency of Human Services
280 State Drive
Waterbury, VT 05671-1080

Chair
Owen.Foster@vermont.gov or successor
Green Mountain Care Board
144 State Street
Montpelier, Vermont 05602

To CMS:

Director, Division of Multi-Payer Models
Katherine.Sapra@cms.hhs.gov or successor
Center for Medicare and Medicaid Innovation
7500 Security Boulevard
Baltimore, MD 21244

The Parties may by advance written notice, change the person and address to which notice is to be directed under this Agreement.

28. Modification.

a. Except as otherwise set forth in this Agreement, the Parties may modify the Agreement, including any Appendix hereto, at any time by mutual written consent.

b. CMS may amend the Agreement or any Appendix hereto without the consent of the State as stated in this Agreement, for good cause or as necessary to comply with applicable federal or State law, regulatory requirements, accreditation standards or licensing guidelines or rules. CMS will include with any such amendment an explanation of the reasons for the amendment.

c. To the extent practicable, CMS will provide the State with 30 days advance written notice of any unilateral amendment, which notice will specify the amendment's effective date. If such amendment violates the law of the State, the Parties will promptly seek modification of the amendment. If modification of the amendment is impracticable or consensus cannot be reached, CMS may terminate the Implementation Period, any waivers under the Model, and/or this Agreement in accordance with Section 20 of the Agreement.

29. Entire Agreement.

This Agreement, including all Recitals and Appendices, constitutes the entire agreement between the Parties. The Parties may amend this Agreement or any Appendix hereto pursuant to Section 28 except as otherwise noted in this Agreement or any Appendix hereto.

30. Precedence.

If any provision of this Agreement conflicts with a provision of any documents incorporated herein by reference, the provision of this Agreement must prevail.

[SIGNATURE PAGE FOLLOW]

Each party is signing the Agreement on the date stated opposite that party's signature. If a party signs but fails to date a signature, the date that the other party receives the signing party's signature will be deemed to be the date that the signing party signed the Agreement. This Agreement and any amendments hereto may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement. This Agreement and any amendments hereto may be signed by autopen or electronic signature (e.g., DocuSign or similar electronic signature technology) and may be transmitted by electronic means. Copies of this Agreement and any amendments hereto that are so executed and delivered have the same force and effect as if executed with handwritten signatures and physically delivered.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Date: _____

By: _____

Liz Fowler

GOVERNOR OF THE STATE OF VERMONT

Date _____

By: _____

Governor Phil Scott

SECRETARY VERMONT AGENCY OF HUMAN SERVICES

Date _____

By: _____

Jenney Samuelson

CHAIR OF THE GREEN MOUNTAIN CARE BOARD

Date _____

By: _____

Owen Foster

Appendix A: Calculation Methodology for the Medicare FFS TCOC Targets

Appendix A details the Calculation Methodology for the Medicare FFS TCOC Targets that CMS will use to determine if the State has met its Medicare FFS TCOC Target described in Section 10.a of the Agreement on an annual basis for each PY of the Model.

Definitions. The following terms, as defined here, will be used for purposes of the calculation methodology described in this Appendix:

"Baseline Year Spending" is equal to annual PBPY Medicare FFS Beneficiary expenditures for beneficiaries residing in the State for each of three baseline years (BYs).

"Baseline PBPY" is the result of blending the risk adjusted, trended Baseline Year Spending for each baseline year as described in Steps 1-3 below.

"Trend Factor" is the annual growth rate, calculated as the weighted average of the adjusted United States Per Capita Cost (USPCC) and AHEAD Accountable Care Prospective Trend (ACPT). The USPCC is adjusted to align with the inclusions and exclusions used to calculate Medicare FFS PBPY expenditures (i.e., to include hospice and exclude uncompensated care, corresponding to the differences in services included in the Medicare FFS TCOC Target and Medicare Advantage rates). The Trend Factor is designed to match the expected TCOC growth in the absence of model participation.

"Savings Component" is the value subtracted from the Trend Factor to produce savings over time compared to the expected TCOC growth in the absence of AHEAD, as listed in Section 10.a. of the Agreement for each PY.

"Annual Growth Factor" means the Trend Factor for the relevant PY minus the Savings Component for that PY.

"Compounded Growth Factor" is the value determined by compounding the Annual Growth Factor for the relevant PY and any previous PYs (e.g., the Compounded Growth Factor for PY2 is equivalent to the Annual Growth Factor for PY1 multiplied with the Annual Growth Factor for PY2).

"Effective Compounded Growth Factor" is the Compounded Growth Factor reweighted between dollar and percentage-based approaches as described in Step 6.

"National Baseline PBPY" is equal to annual PBPY Medicare FFS Beneficiary expenditures for all national beneficiaries for the baseline years, which is risk standardized, trended, and blended following the same methodology as described in Steps 1-3 below. This amount is used solely to quantify the dollar-based share of Step 6.

Calculation Methodology:

Step 1: Calculate Baseline Year Spending for Medicare FFS Beneficiaries residing in the State for the Baseline Years.

a. All Medicare FFS expenditures for Medicare FFS Beneficiaries residing in the State, regardless of the location where services were provided, will be included in the Baseline Year Spending. Baseline Year Spending includes claims and non-claims-based payments, including those Medicare payments made for participation in shared savings programs and other CMMI models. It includes spending for Part A only and Part B only beneficiaries as well as beneficiaries enrolled in both Parts and any months during which the beneficiary was a resident of the State.
b. The BYs remain fixed throughout the Implementation Period.
c. The weighting that will be used for Baseline Year Spending in each BY is as follows in Table 1:

Table 1: Baseline Year Weights

Baseline Year	**Calendar Year**	**Weighting**	**Baseline Year Spending PBPY**
Baseline Year 1	2021	0%	Not Applicable
Baseline Year 2	2022	0%	Not Applicable
Baseline Year 3	2023	100%	$12,040

(Weighting will be applied in Step 3).

Step 2: Apply risk adjustment to each BY to standardize historical spending to a 1.0 score basis relative to national. Risk adjustment will account for beneficiary demographics and health conditions within the State. For each of the baseline years, CMS will divide Baseline Year Spending by the State's average normalized Hierarchical Condition Categories (HCC) score for that baseline year. The State's average normalized HCC score will be determined by applying the most recent CMS-HCC Risk Adjustment Model (currently Version 28) to claims from the baseline year for all Medicare FFS Beneficiaries who resided in the State during the baseline year. Beneficiary normalized HCC scores will be weighted using the number of months each beneficiary resided in the State to construct the State average normalized HCC score.

Step 3: Apply the adjusted observed USPCC (actual historical) to Risk Adjusted Baseline Year Spending for BYs 1 and 2 to standardize it to Baseline Year Spending for BY 3 and blend the periods based on weighting in Table 1 to derive the baseline PBPY.

Step 4: Determine the Trend Factor. The Trend Factor represents a mechanism to update Baseline PBPY to the applicable PY. It is constructed as a weighted average of (1) the adjusted USPCC and (2) AHEAD Accountable Care Prospective Trend (ACPT). The ACPT is an administratively set prospective growth rate based on the adjusted USPCC, prospectively set for a five-year period, similar to the rate used in the Medicare Shared Savings Program. Though the ACPT is fixed for a five-year period, the annual ACPT rate in any given PY is not necessarily the same as the rate in other PYs (e.g., the ACPT may be 3% for PY1, 2.5% for PY2, 3.2% for PY3, etc.).

In advance of PY1, CMS will calculate an AHEAD ACPT for PY1 through PY5. CMS will notify the State of the AHEAD ACPT for PY 1 through PY5 at least 90 days prior to the start of

PY 1. CMS will calculate an updated AHEAD ACPT for PY 6 through PY 9 and will share the AHEAD ACPT at minimum 90 days in advance of PY 6.

a) In determining the trend factor for the upcoming PY, the adjusted projected USPCC (that is, a prospective estimate of the growth rate for the upcoming year) will be included for the current PY's component of the Trend Factor, and the adjusted observed USPCC (actual historical) will be included for Trend Factor components pertaining to all prior years elapsed between baseline and the applicable PY, including calendar years between BY3 and PY1. No savings component or ACPT are applied to growth rates corresponding to calendar years prior to PY1.
b) In determining the Trend Factor for PY1, the (1) adjusted USPCC will represent 90% of the weight while the (2) AHEAD ACPT will represent 10%. In determining the Trend Factor for each successive PY, the (1) adjusted USPCC share will be decreased by 4% while the (2) AHEAD ACPT share will be increased by 4% until the (1) adjusted USPCC share is 58% and the (2) AHEAD ACPT share is 42% in PY9 as indicated in Table 2 below.
c) CMS may, in its sole discretion, prospectively adjust the weighting of the AHEAD ACPT used in calculating the Medicare FFS TCOC Target for a given PY in order to better align with the Medicare Shared Savings Program and other Innovation Center models or if growth rates deviate substantially from the AHEAD ACPT as a result of an Exogenous Factor. If the State believes that an Exogenous Factor has occurred, it can request that CMS adjust the Medicare FFS TCOC Target for a given PY to not use the AHEAD ACPT using the process described in Section 10.h, "Exogenous Factors."

Table 2: Blended Trend Factor Approach

Annual Growth Factor applied to:	% of Trend Factor USPCC	% of Trend Factor ACPT
PY1	90%	10%
PY2	86%	14%
PY3	82%	18%
PY4	78%	22%
PY5	74%	26%
PY6	70%	30%
PY7	66%	34%
PY8	62%	38%
PY9	58%	42%

Step 5: Determine the Annual Growth Factor and then determine the Compounded Growth Factor. The Annual Growth Factor is determined by subtracting the Savings Component from the Trend Factor. The Compounded Growth Factor is determined by compounding the Annual Growth Factor based on the applicable PY and the previous PYs, if any (e.g., the Compounded Growth Factor for PY3 would be calculated by multiplying the Annual Growth Factors (before compounding) for each of PY1 through PY3).

The Savings Component for each PY is listed in Section 10.a.

Step 6: Apply the Effective Compounded Growth Factor to the Baseline PBPY. The Compounded Growth Factor will be applied to the Baseline PBPY using a blend of dollar-based approach (1/3 weight) and percentage-based approach (2/3 weight) to control for regression to the mean and therefore must first be translated to an effective amount as described in the formulas under Step 7. The dollar-based approach involves increasing the Baseline PBPY by the year-over-year change in adjusted USPCC, measured in dollars PBPY. Growth allowed by the dollar-based approach does not depend on the Baseline PBPY. The percentage-based approach involves increasing the Baseline PBPY at the same rate of growth as adjusted USPCC.

Step 7: Constructing the annual Medicare FFS TCOC Target. After the Effective Compounded Growth Factor is applied to the Baseline PBPY, CMS will multiply the result by the average normalized HCC score for the State to determine the Medicare FFS TCOC Target for the applicable PY. The State's average normalized HCC score will be determined by applying the 2024 CMS-HCC Risk Adjustment Model (Version 28) to the most recent year of available claims for all beneficiaries who resided in the State during the year associated with those claims. Medicare FFS Beneficiary normalized HCC scores will be weighted using the number of months each beneficiary resided in the State to construct the State's average normalized HCC score.

Illustration of the Medicare FFS TCOC Target (Steps 1-7)

For illustration of the compounding mechanism and its application to the Baseline PBPY, below is a sample calculation to construct the Medicare FFS TCOC Target for a hypothetical PY5:

BY = baseline year

PY = Performance Year

TF = Trend Factor

SC = Savings Component

(Note: the TF-SC = Annual Growth Rate, however each is noted individually below for additional clarity).

The Baseline PBPY is calculated as the sum of the following steps (Steps 2 and 3):

- HCC risk standardized and trended BY1 = risk adjusted BY1* USPCC for BY2* USPCC for BY3 * BY1 weight from Table 1.
- HCC risk standardized and trended BY2 = risk adjusted BY2*USPCC for BY3* BY2 weight from Table 1.
- HCC risk standardized and trended BY3 = risk adjusted BY3 * BY3 weight from Table 1.

The Compounded Growth Factor is as follows (Steps 4 and 5):

Compounded Growth Factor = (1+TF PY5 – SC PY5)*(1+TF PY4 – SC PY4)* … *(1+TF PY1 – SC PY1)

The Compounded Growth Factor is translated to the **Effective Compound Growth Factor described in Step 6**.

Effective Compounded Growth Factor = .67 * Compounded Growth Factor + .33 * (Compounded Growth Factor * National Baseline PBPY/Baseline PBPY)

Medicare FFS TCOC Target (Step 7) =

Baseline PBPY*Effective Compound Growth Factor*Average normalized HCC score for the State for the applicable PY

Step 8: **Following a given PY, CMS will calculate the State's Medicare FFS PBPY expenditures for that PY to determine the State's performance on the Medicare FFS TCOC Target.**

a) CMS will calculate Medicare FFS expenditures for a given PY by adding together the following two fractions: (a) Medicare Part A expenditures per Medicare FFS Beneficiary with Part A residing in the State; and (b) Medicare Part B expenditures per Medicare FFS Beneficiary with Part B residing in the State.
   i. The calculation of Medicare FFS expenditures will include all Part A and Part B expenditures for State resident Medicare FFS Beneficiaries, regardless of the state of service.
   ii. The calculation of Medicare FFS expenditures will include non-claims based payments.
   iii. The number of State resident Medicare FFS Beneficiaries with Part A and State resident Medicare FFS Beneficiaries with Part B will be determined using average monthly enrollment during the 12 months of the Performance Year.
   iv. To determine the Medicare Part A expenditures per Medicare FFS Beneficiary with Part A residing in the State, CMS will divide the total Part A expenditures as calculated in accordance with Step 8.a.i. of this Appendix above by the number of State resident Medicare FFS Beneficiaries with Part A as calculated in accordance with Step 8.a.iii. of this Appendix.
   v. To determine the Medicare Part B expenditures per Medicare FFS Beneficiary with Part B residing in the State, CMS will divide the total Part B expenditures as calculated in accordance with Section 8.a.i above by the number of State resident Medicare FFS Beneficiaries with Part B as calculated in accordance with Step 8.a.iii of this Appendix.
   vi. CMS and the State understand that Medicare billing rules and requirements may change during the Agreement Term. Consistent with Section 28 of this Agreement, CMS and the State may amend this Agreement to modify the savings calculation methodology described in this Appendix A.

b) CMS will include the EPCP in the Medicare FFS PBPY expenditures calculations beginning in PY1.

Step 9:

a. **Compare the actual Medicare FFS national annual growth rate (adjusted observed USPCC) to the actual Medicare FFS TCOC State annual growth rate for the year(s) between BY 3 and PY 1.** Following PY1, CMS will compare the adjusted observed USPCC growth rate for 2024 and 2025 to the actual Medicare FFS TCOC State annual growth rate for each year. If the actual Medicare FFS TCOC State annual growth rate in any year differs from the adjusted observed USPCC growth rate for that year by more than one percentage point, in either direction, CMS will add one-half of the difference between the actual Medicare FFS TCOC State annual growth rate and the adjusted observed USPCC growth rate beyond one percentage point to the adjusted observed USPCC growth rate to establish a modified adjusted observed USPCC growth rate for that year. The modified USPCC rates will then be used to calculate revised Trend Factors for 2024 and 2025 during PY1, and will be used in setting Medicare FFS TCOC Targets for PY1 and all subsequent PYs in accordance with the methodology described in Step 4.

b. **Compare the actual Medicare FFS national annual growth rate (adjusted observed USPCC) to the projected Medicare FFS national annual growth rate (adjusted projected USPCC) for the PY.** Following each PY, CMS will compare the adjusted observed USPCC to the adjusted projected USPCC used in Step 4 to calculate the Trend Factor for the applicable PY. If the adjusted observed USPCC deviates from the adjusted projected USPCC by more than 1 percentage point, in either direction, CMS will add half of the difference between the adjusted observed and adjusted projected USPCC beyond one percentage point to the adjusted projected USPCC and will calculate a revised Trend Factor and Medicare FFS TCOC Target for the applicable PY. This reconciled USPCC will be used to calculate the revised Trend Factor for the applicable PY in accordance with the methodology described in Step 4.

Step 10: **Compare the observed Medicare FFS PBPY expenditures calculated in Step 8 to the Medicare FFS TCOC Target for that PY.** CMS will compare the State's Medicare FFS PBPY expenditures for the PY to the State's Medicare FFS TCOC Target and report to the State on its performance following each PY.

Appendix B: Medicare FFS Primary Care Investment Target

CMS will determine the State's performance against the Medicare FFS Primary Care Investment Target, described in Section 10 of the Agreement, using the calculation methodologies described in this Appendix.

Medicare FFS Primary Care Investment Target Methodology

CMS will measure the State's performance on the Medicare FFS Primary Care Investment Target for each PY using the following equation:.

$$\textit{State Performance for a Given Performance Year} = \frac{\textit{State Performance for a Given Performance Year}}{\textit{Medicare FFS TCOC in that PY}}$$

The **Sum of Medicare FFS Primary Care Expenditures** in the PY will be calculated by CMS based on Medicare FFS claims for a CMS-specified list of specialty codes, HCPCS codes, and Non-Claims-Based Payments (NCBPs) for services provided to Vermont beneficiaries with both Medicare Parts A and B. In advance of each PY, CMS will provide the State with the list of codes that will be included in the calculation of the **Sum of Medicare FFS Primary Care Expenditures** for that PY for purposes of assessing the State's performance on the Medicare FFS Primary Care Investment Target.

The **Medicare FFS TCOC expenditures** in the PY is the State's Medicare FFS PBPY expenditures calculated by CMS in accordance with Step 8 of the methodology set forth in Appendix A of this Agreement for the applicable PY when applied only to Vermont beneficiaries covered by both Medicare Parts A and B.

The State's Medicare FFS Primary Care Investment Targets for each PY are as follows:

Medicare FFS Primary Care Investment Targets

PY	Annual Medicare FFS Primary Care Investment Target
PY1	4.47%
PY2	X%
PY3	
PY4	
PY5	
PY6	
PY7	
PY8	
PY9	Final Attainment Goal: 5.17%

Appendix C. Calculation Methodology for Medicaid Hospital Global Budgets

The State's proposed Medicaid Hospital Global Budget methodology must comply with the alignment requirements below in addition to any requirements from the Center for Medicaid and CHIP Services (CMCS) pertaining to the federal authority pathway the state is using to implement Medicaid hospital global budgets. If CMS approves the State's Medicaid Hospital Global Budget, the State must continue to comply with these requirements while the State is operating their Medicaid Hospital Global Budget under the Model.

1. State will establish annual Medicaid Hospital Global Budgets for Medicaid Participant Hospitals that transition hospitals away from existing volume-based reimbursement and incentivize a reduction in unnecessary Medicaid hospital utilization and improvements in population health. The methodology considers incentives to recruit and retain hospital participation in the Model.

2. The Medicaid Hospital Global Budget will allow for all short-term acute care hospital and critical access hospitals located in the State, at minimum, to be eligible for participation. A SMA may propose including additional types of hospitals (e.g., psychiatric hospitals or children's hospitals). For critical access hospitals, the Medicaid Hospital Global Budget methodology may include accommodations for their participation, however after the end of a PY, the state may not reconcile Medicaid Hospital Global Budget payments to CAHs back to Medicaid costs (if that is historically how CAHs are paid in that state). Long Term Care Hospitals (LTCH) and federally-owned government facilities may not be included in the Medicaid global budget.

3. The Medicaid Hospital Global Budget will cover hospital inpatient and outpatient services. Additions, carveouts, or other changes must be approved by CMS. The SMA may propose including or excluding hospital inpatient and outpatient services that differ from the services included in the Medicare global budgets (e.g., hospital-based dental services). However, the SMA must provide a justification including information on how any excluded services are currently paid for (e.g., FFS, capitation, other value-based arrangement), and any additional information requested by CMS.

4. The Medicaid Hospital Global Budget methodology must account for inflation, population growth, demographic changes, and other factors influencing the cost of hospital care. In addition, Medicaid Hospital Global Budgets must be adjusted for both medical and social risk for either the beneficiaries the hospital serves or the attributed geographic region.

5. The SMA must identify the Medicaid beneficiary groups to be included in the Medicaid Hospital Global Budget methodology. The SMA must also identify beneficiary groups to be excluded from the Medicaid Hospital Global Budget methodology, along with a rationale for their exclusion. This must be included in the SMA's proposed Medicaid Hospital Global Budget methodology in accordance with the model milestones.

6. Medicaid Hospital Global Budgets must be adjusted for performance on quality measures. Quality performance adjustments must be based on the quality outcomes of an attributed patient population. Medicaid Hospital Global Budgets must be adjusted for performance using disparities-sensitive quality measures aimed at improving health equity. At minimum, the selected measures must provide sufficient data to identify disparities and improvements in health equity, and the measures must align with the overall model goals.

7. Medicaid Hospital Global Budgets must account for changes in service line and unplanned volume shifts, while continuing to avoid incentivizing FFS-oriented utilization. SMA must clearly define this process for the Medicaid Hospital Global Budget, including identifying these or other circumstances under which this process would occur (e.g., FFS prospective budget payments, hospital service line changes, eligibility updates, other unplanned programmatic changes beyond a certain revenue threshold, etc.). Federal matching dollars will be returned by the state to the federal government should a recoupment be made because of this process.

Medicaid payments to Participant Hospitals in a Medicaid Hospital Global Budget must be administered by prospective payment or virtual global budget, as described herein.

1. **Prospective payment:** Participant Hospitals will receive a fixed payment amount as calculated in the State's Hospital Global Budget methodology at regular, specified intervals (e.g., biweekly, monthly) over the course of the PY. Following each PY the State must complete a review process of each Participant Hospital' Medicaid Hospital Global Budget to adjust for performance, quality, market shifts, and other factors as outlined in the State's methodology and financial specifications.
2. **Virtual global budget:** Under this option, the State and/or their Managed Care Organizations (MCOs) pay fee-for-service claims for care furnished to Medicaid enrollees under current arrangements and conduct periodic reconciliation to Hospital Global Budget amounts (e.g., monthly, quarterly, annually). The State must develop and administer a defined reconciliation process to true up the claims payments against the prospectively set Hospital Global Budgets.

Appendix D: Hospital Global Budget Alignment Requirements for Proposed State-Designed Medicare FFS Hospital Global Budget Methodology

The Proposed State-Designed All-Payer Hospital Global Budget Methodology must comply with the alignment requirements below. If CMS approves the State-Designed All-Payer Hospital Global Budget Methodology, the State must continue to comply with these requirements while the State is operating their State-Designed Medicare FFS Hospital Global Budget Methodology under the Model.

General Requirements.

1. The Proposed State-Designed Medicare FFS Hospital Global Budget Methodology must establish annual Hospital Global Budgets for Participant Hospitals that transition hospitals away from existing volume-based reimbursement and incentivize a reduction in unnecessary hospital utilization.

2. The Proposed State-Designed All-Payer Hospital Global Budget Methodology will include facility services in hospital inpatient, and outpatient, and emergency departments. Additions, carveouts, or other changes must be approved by CMS. In its proposal for such a change, the State must provide a justification including information on how any excluded services are currently paid for (e.g., FFS, capitation, other value-based arrangement), and any additional information requested by CMS.

3. The Proposed State-Designed All-Payer Hospital Global Budget Methodology will allow for all short-term acute care hospitals and CAHs located in the State, at a minimum, to be eligible for participation. The State may propose including additional types of hospitals (e.g., psychiatric hospitals, or children's hospitals).

4. The Proposed State-Designed All-Payer Hospital Global Budget Methodology must be designed in such a way that enables the state to both meet its annual Medicare FFS TCOC Targets and achieve savings by the conclusion of the Agreement Term. The methodology must include a process by which hospital global budgets can be adjusted in the event the State misses the Medicare FFS TCOC Target(s) and is on a Corrective Action Plan.

5. The Proposed State-Designed All-Payer Hospital Global Budget Methodology must consider incentives to recruit and retain hospitals early into the Model, and to facilitate hospital investment in the infrastructure needed to be successful under a hospital global budget construct (e.g., an upward adjustment to hospital global budgets for the first two Performance Years, similar to the HGBOI).

6. The Proposed State-Designed All-Payer Hospital Global Budget Methodology must adjust for both medical and social risk for either the beneficiaries the hospital serves or the hospital's geographic service area. The methodology must account for population growth, demographic changes, and other factors influencing the cost of hospital care.

7. The Proposed State-Designed Medicare FFS Hospital Global Budget Methodology must include a mechanism by which a Participant Hospital's Hospital Global Budget is

adjusted for hospital-level quality performance based on the quality outcomes of an attributed patient population. This quality adjustment must be based on performance on either the CMS national hospital quality programs or on similar categories of quality measures to those used for these programs. Hospital Global Budgets must be adjusted for performance using disparities-sensitive quality measures aimed at improving health equity. At a minimum, the selected measures must provide sufficient data to identify disparities and improvements in health equity, and the measures must align with the overall model goals.

8. The Proposed State-Designed Medicare FFS Hospital Global Budget Methodology must hold hospitals accountable for TCOC of a defined beneficiary population via a performance adjustment (e.g., CMS's TCOC Performance Adjustment) or some other mechanism.

9. The Proposed State-Designed Medicare FFS Hospital Global Budget Methodology must account for changes in service line and unplanned volume shifts, while continuing to avoid incentivizing FFS-oriented utilization. The State must clearly state the process for accounting for these changes in the Hospital Global Budget, including identifying these or other circumstances under which this process would occur (e.g., FFS prospective budget payments, hospital service line changes, eligibility updates, other unplanned programmatic changes beyond a certain revenue threshold, etc.).

10. The Proposed State-Designed Medicare FFS Hospital Global Budget Methodology must account for annual changes, such as inflation.

11. While the methodology may include modifications to account for the unique circumstances of critical access hospitals (as CMS's methodology does), the hospital global budgets for CAHs may not be reconciled back to costs.

12. The Proposed State-Designed Medicare FFS Hospital Global Budget Methodology must calculate payments as a bi-weekly lump sum.

13. Methodology algorithms must be disclosed to CMS so CMS can replicate and validate the state's hospital global budget calculations.

Appendix E: Primary Care AHEAD Quality Measures

The measures identified in this Appendix E operate in a manner consistent with all applicable Medicare laws, rules, and regulations, as amended or modified from time to time, and applicable NCQA rules and guidance, as amended or modified from time to time.

Domain	Measure	Identifier	Steward	Data Source	Payer and Program Alignment
Behavioral Health (30%) Measure is Required	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	‡CBE 0418e; CMIT 672	CMS	eCQM	Medicaid Adult Core Set; Commercial; Making Care Primary; CPC; UDS
Prevention & Wellness (15%) Choose at least 1	*Colorectal Cancer Screening (COL-AD)	CBE 0034 CMIT 139	NCQA	eCQM	Medicaid Adult Core Set; Commercial; Making Care Primary; Primary Care First; CPC+; CPC; UDS
	*Breast Cancer Screening: Mammography (BCS-AD)	CBE 2372 CMIT 93	NCQA	eCQM	Medicaid Adult Core Set; Medicare; Marketplace; Commercial; CPC+; CPC; UDS
Chronic Conditions (15%) Choose at least 1	*+^Controlling High Blood Pressure (CBP-AD)	CBE 0018 CMIT 167	NCQA	eCQM	Medicaid Adult Core Set; Medicare; Marketplace; Commercial; Making Care Primary; Primary Care First;

					CPC+; CPC; UDS
	*+^ Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	CBE 0059 CMIT 204	NCQA	eCQM	Medicaid Adult Core Set; Medicare; Marketplace; Making Care Primary; Primary Care First; CPC+; CPC; UDS
Health Care Utilization (40%) Both measures are required	Emergency Department Utilization (EDU)	N/A	NCQA	Claims	Commercial; Making Care Primary; CPC+
	Acute Hospital Utilization (AHU)	N/A	NCQA	Claims	Commercial; Primary Care First; CPC+

CBE = Consensus-based Entity (previously National Quality Forum/NQF)

CMIT = Centers for Medicare & Medicaid Services Measures Inventory Tool

UDS = Health Resources and Services Administration (HRSA) Uniform Data System measures

*Included in CMS Universal Foundation

+ Aligned with CMCS Health Equity Set

‡ = Measure is no longer endorsed by the CBE

^Aligned with Medicare Advantage

Appendix F: Medicare Payment Waivers and Benefit Enhancements

Medicare Payment Waivers. Subject to the provisions of the Agreement and as specified in this Appendix, CMS will waive the requirements of the following provisions of the Act, as necessary, for purposes of testing the Model:

1. IPPS. Sections 1886(d), 1886(g), and 1886(b)(1) of the Act and implementing regulations at 42 C.F.R 412, subparts A through M.
2. OPPS. Section 1833(t) of the Act and implementing regulations at 42 C.F.R. Part 419; Sections 1861(kkk)(1) and 1834(x)(1) of the Act, as these Section pertains to rural emergency hospital (REH) services paid under OPPS with a 5% payment increase; and Sections 1834(x)(2), 1834(x)(5)(B) and 1817 of the Act, as these Sections pertain to additional monthly facility payment to REH facilities from Federal Hospital Insurance Trust Fund.
3. Medicare Hospital Value Based Purchasing Program. Section 1886(o) of the Act, and implementing regulations at 42 C.F.R. § 412.160, et seq.
4. Hospital Inpatient Quality Reporting Program. Section 1886(b)(3)(B)(viii) of the Act.
5. Hospital Outpatient Quality Reporting Program. Section 1833(t)(17)(A) of the Act.
6. Rural Emergency Hospital Quality Reporting Program. Section 1861(kkk)(7) of the Act.
7. Medicare Hospital Readmissions Reduction Program. Section 1886(q) of the Act, and implementing regulations at 42 C.F.R. §§ 412.152 and 412.154.
8. Medicare Hospital Acquired Conditions Program. Section 1886(p) of the Act, and implementing regulations at 42 C.F.R. § 412.172.
9. Medicare Promoting Interoperability Program. Section 1886(b)(3)(B)(ix) of the Act, and implementing regulations at 42 C.F.R. § 412.64.
10. Payment for Post-Hospital Skilled Nursing Facility (SNF) Care Furnished by a Critical Access Hospital with Swing-bed Approval. Section 1883(a)(3) of the Act and 42 C.F.R. § 413.114(a).
11. Periodic Interim Payments Made to CAHs. Section 1815(e)(2) of the Act and 42 C.F.R. § 413.64(h)(2)(vi).
12. Conditions of Payment for Inpatient Services Furnished at CAHs (CAH 96-Hour Certification). Section 1814(a)(8) of the Act and 42 C.F.R. § 424.15.

Benefit Enhancements. Subject to the provisions of the Agreement and the applicable Participation Agreement, and as specified in this Appendix, CMS will waive the requirements of the following provisions of the Act, as necessary, for purposes of testing the Model, and providing Participant Hospitals and Participant Primary Care Practices, as applicable, the opportunity to provide Beneficiary Enhancements, subject to certain requirements in their associated Participation Agreement and applicable statutes, rules or regulations administered by the Federal government.

1. Home Health Homebound Benefit Enhancement. Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act, and implementing regulations at 42 C.F.R. 409.42;
2. Care Management Home Visit Benefit Enhancement. 42 C.F.R. 410.26(b)(5)
3. Post-Discharge Home Visits Benefit Enhancement. 42 C.F.R. 410.26(b)(5)
4. 3-day SNF Rule Waiver Benefit Enhancement. Section 1861(i) of the Act
5. Nurse Practitioner and Physician Assistant Services Benefit Enhancement. Sections 1814(a)(7)(A)(i)(I) and Section 1861(s)(12)(A) of the Act and implementing regulations at 42 C.F.R. 410.12; Section 1861(eee)(2)(C) of the Act; Section 1861(iii)(1)(B) of the Act and implementing regulations at 42 C.F.R. § 414.1515(c); and Section 1861(vv)(1) of the Act and implementing regulations at 42 C.F.R. § 410.132(c).
6. Concurrent Care for Hospice Beneficiaries Benefit Enhancement. Section 1812 of the Act and implementing regulations at 42 C.F.R. § 418.24(e)(2).
7. Telehealth Benefit Enhancement. Section 1834(m)(4)(B)-(C) of the Act and implementing regulations at 42 C.F.R. § 410.78(b)(3)–(4); Section 1834(m)(2)(B) of the Act and implementing regulations at 42 C.F.R. § 414.65(b); Section 1834(m)(1) of the Act and implementing regulations at 42 C.F.R. § 410.78(a)(3) and 42 C.F.R. § 410.78(b); Section 1834(m)(4)(E) of the Act and implementing regulations at 42 C.F.R. § 410.78 (b)(2).

Appendix G: Statewide Quality Measures

Table 1. Core Statewide Measures

Domain	Measure	Identifier	Steward	Payer Alignment	Data Sources
Population Health	CDC HRQOL– 4 Healthy Days Core Module	____	____	____	BRFSS
Prevention & Wellness *Choose at least 1*	*+^Colorectal Cancer Screening (CCS-AD)	CBE 0034 CMIT 139	NCQA	Medicaid Adult Core Set; Medicare; Marketplace; Commercial	Claims or EHR data
	*^Breast Cancer Screening: Mammography (BCS-AD)	CBE 2372 CMIT 93	NCQA	Medicaid Adult Core Set; Medicare; Marketplace; Commercial	Claims or EHR data
Chronic Conditions *Choose at least 1*	*+^ Controlling High Blood Pressure (CBP-AD)	CBE 0018 CMIT 167	NCQA	Medicaid Adult Core Set; Medicare; Marketplace; Commercial	Claims, hybrid, or EHR
	*+^Hemoglobin A1c Control for Patients with Diabetes (HBDAD)	CBE 0059/0575 CMIT 204/147	NCQA	Medicaid Adult Core Set; Medicare; Marketplace	Claims, hybrid, or EHR
Behavioral Health *Choose at least 1*	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	CBE 3400 CMIT 750	CMS	Medicaid Adult Core Set	Claims
	^Antidepressant Medication Management (AMMAD)	CBE 0105 CMIT 63	NCQA	Medicaid Adult Core Set; Commercial	Claims or EHR
Domain	**Measure**	**Identifier**	**Steward**	**Payer Alignment**	**Data Sources**

	+^Follow-Up After Hospitalization for Mental Illness (FUHAD)	CBE 0576 CMIT 268	NCQA	Medicaid Adult Core Set; Medicaid and CHIP Child Core Set; Medicare Shared Savings; Commercial	Claims
	Follow-up after ED Visit for Substance Use	CBE 3488 CMIT 264	CMS	Medicaid Adult Core Set;	Claims
Health Care Quality and Utilization	*^Plan All-Cause Unplanned Readmission (PCRAD)	CBE 1768 CMIT 561	NCQA	Medicaid Adult Core Set; Medicare Part C; Marketplace; Commercial	Claims

* Included in CMS Universal Foundation

+ Aligned with CMCS Health Equity Set

^ Aligned with Medicare Advantage

CBE = Consensus-based Entity (previously National Quality Forum/NQF)

CMIT = Centers for Medicare & Medicaid Services Measures Inventory Tool

Table 2. Statewide Optional Measures

Domain	**Measure**	**Identifier**	**Steward**	**Payer Alignment**	**Data Sources**
Maternal Health Outcomes	+Live Births Weighing Less than 2500 grams (LBW-CH)	CBE 1382 CMIT 413	CDC/NCHS	Medicaid and CHIP Child Core Set	State vital records
	+Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	CBE 1517 CMIT 581	NCQA	Medicaid Adult Core Set; Marketplace	Claims or hybrid

Prevention Measures	*Adult Immunization Status	CBE 3620 CMIT 26	NCQA	Commercial	Claims, Electronic Health Data, EHR, Enrollment Data, Management Data, Registry Data
	Prevalence of Obesity	____		____	BRFSS
	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	CBE 0027 CMIT 432	NCQA	Medicaid Adult Core Set	Survey
	ED Visits for Alcohol and Substance Use Disorders[#]	CMMI in-house measure	CMS	Not Available Yet	Claims
Social Drivers of Health	Food Insecurity	____		____	USDA Current Population Survey or equivalent
	Housing Quality	____		____	American Housing Survey; Census Bureau or equivalent

* Included in CMS Universal Foundation

+ Aligned with CMCS Health Equity Set

[#] Measure in development by CMMI with Yale CORE

Appendix H: The Vermont Agency of Human Services Attestation and Data Specification Worksheet

HIPAA-Covered Disclosure Request Attestation

The Vermont Agency of Human Services (AHS) requests the CMS data listed in the Data Specification Worksheet below and makes the following assertions regarding its ability to meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements for receiving such data:

- The AHS affirms that it is a "health oversight agency" as defined in 45 C.F.R. § 164.501 and represented in Section 15 (Data Sharing) of this Agreement.

The AHS is seeking protected health information (PHI), as defined in 45 C.F.R. § 160.103 (select one):

- For its own "oversight activities" as specified in the HIPAA Privacy Rule at 45 C.F.R. § 164.512(d).
- Other: Please attach a description of the intended use.

The AHS requests (select one):

- For the Medicare FFS beneficiaries who reside in Vermont, the AHS requests: (i) three years of historical data files for each performance year of the Model consisting of the data elements identified in the Data Specification Worksheet for Initiative Beneficiaries; and (ii) monthly claims data files for all Initiative Beneficiaries for the data elements identified in the Data Specification Worksheet, from the following CMS Integrated Data Repository (IDR) data files:
    - IDR Medicare Part A and Part B claims and eligibility data (NOTE: file name TBD)
    - IDR Medicare Part D data (DRX09 - IDR RESTRICTED ACCESS TO LIMITED MEDICARE PART D CLAIM DATA (NO FINANCIAL PAYMENT COLUMNS).)
- Other: Please attach a detailed description of the data requested.

The data requested is (select one):

- **The "minimum necessary" (as defined at 45 C.F.R. § 164.502(b)) to carry out the oversight activities described above.**
- Other: Please attach a description of how (if applicable) the data requested exceeds what is needed to carry out the work described above.

The AHS's data custodian(s) for the requested data are as follows:

1. Geoffrey Battista
   Vermont Agency of Human Services
   280 State Drive, Waterbury, Vermont 05676

geoffrey.battista@vermont.gov
(802) 798-4645

Data Specification Worksheet

Data Element Source	Data Element	Data Element Description
Part A Claims	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Provider OSCAR Number	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 10=HHA claim 20=Non swing bed SNF claim 30=Swing bed SNF claim 40=Outpatient claim 50=Hospice claim 60=Inpatient claim 61=Inpatient "Full-Encounter" claim
	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
	Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.
	Claim Bill Facility Type Code	The first digit of the type of bill (TOB1) is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are: 1=Hospital 2=SNF 3=HHA 4=Religious non-medical (hospital) 5=Religious non-medical (extended care) 6=Intermediate care 7=Clinic or hospital-based renal dialysis facility 8=Specialty facility or Ambulatory Surgical Center (ASC) surgery 9=Reserved
	Claim Bill Facility Type Code	The first digit of the type of bill (TOB1) is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF).
		Claim Facility Type Codes are:
		1=Hospital

		2=SNF
		3=HHA
		4=Religious non-medical (hospital)
		5=Religious non-medical (extended care)
		6=Intermediate care
		7=Clinic or hospital-based renal dialysis facility
		8=Specialty facility or Ambulatory Surgical Center (ASC) surgery
		9=Reserved
	Claim Bill Classification Code	The second digit of the type of bill (TOB2) is used to indicate with greater specificity where the service was provided (e.g., a department within a hospital).
	Principal Diagnosis Code	The International Classification of Diseases (ICD)-9/10 diagnosis code identifies the beneficiary's principal illness or disability.
	Admitting Diagnosis Code	The ICD-9/10 diagnosis code identifies the illness or disability for which the beneficiary was admitted.
	Claim Medicare Non Payment Reason Code	Indicates the reason payment on an institutional claim is denied.
	Claim Payment Amount	Amount that Medicare paid on the claim.
	Claim NCH Primary Payer Code	If a payer other than Medicare has primary responsibility for payment of the beneficiary's health insurance bills, this code indicates the responsible primary payer.
	Federal Information Processing Standards FIPS State Code	Identifies the state where the facility providing services is located.
	Beneficiary Patient Status Code	Indicates the patient's discharge status as of the Claim Through Date. For example, it may indicate where a patient was discharged to (e.g., home, another facility) or the circumstances of a discharge (e.g., against medical advice, or patient death).
	Diagnosis Related Group Code	Indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes.
	Claim Outpatient Service Type Code	Indicates the type and priority of outpatient service.
		Claim Outpatient Service Type Codes are:
		0=Blank
		1=Emergency
		2=Urgent
		3=Elective
		5-8=Reserved
		9=Unknown

	Facility Provider NPI Number	Identifies the facility associated with the claim. Each facility is assigned its own unique NPI.
	Operating Provider NPI Number	Identifies the operating provider associated with the claim. Each provider is assigned its own unique NPI.
	Attending Provider NPI Number	Identifies the attending provider associated with the claim. Each provider is assigned its own unique NPI.
	Other Provider NPI Number	Identifies the other providers associated with the claim. Each provider is assigned its own unique NPI.
	Claim Adjustment Type Code	Claim adjustment types (Original, Adjustment, Deleted, Resubmitted, etc.)
	Claim Effective Date	Date the claim was processed and added to the NCH. Also referred to as the NCH Weekly Processing Date.
	Claim IDR Load Date	When the claim was loaded into the IDR.
	Beneficiary Equitable BIC HICN Number	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level.
	Claim Admission Type Code	Indicates the type and priority of inpatient services.
		Claim Admission Type Codes are:
		0=Blank
		1=Emergency
		2=Urgent
		3=Elective
		4=Newborn
		5=Trauma Center
		6-8=Reserved
		9=Unknown
	Claim Admission Source Code	Indicates the source of the beneficiary's referral for admission or visit (e.g., a physician or another facility).
		Find Admission Source Codes here: http://www.resdac.org/cms-data/variables/Claim-Source-Inpatient-Admission-Code
	Claim Bill Frequency Code	The third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided).
		Find Claim Frequency Codes here: http://www.resdac.org/cms-data/variables/Claim-Frequency-Code.
	Claim Query Code	Indicates the type of claim record being processed with respect to payment (e.g., debit/credit indicator or interim/final indicator).
		Claim Query Codes are:
		0=Credit adjustment
		1=Interim bill
		2=HHA benefits exhausted

		3=Final bill
		4=Discharge notice
		5=Debit adjustment
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Part A Claims Revenue Center Details	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Claim Line Number	A sequential number that identifies a specific claim line
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
		Claim type codes are:
		10=HHA claim
		20=Non swing bed SNF claim
		30=Swing bed SNF claim
		40=Outpatient claim
		50=Hospice claim
		60=Inpatient claim
		61=Inpatient “Full-Encounter” claim
	Claim Line From Date	The date the service associated with the line item began.
	Claim Line Thru Date	The date the service associated with the line item ended.
	Product Revenue Center Code	The number a provider assigns to the cost center to which a particular charge is billed (e.g., accommodations or supplies).
	Claim Line Institutional Revenue Center Date	The date that applies to the service associated with the Revenue Center code.
	HCPCS Code	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
	Beneficiary Equitable BIC HICN Number	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level.

	Provider OSCAR Number	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.
	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
	Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.
	Claim Line Service Unit Quantity	The number of dosage units of medication that were dispensed in this fill.
	Claim Line Covered Paid Amount	The amount Medicare reimbursed the provider for covered services associated with the claim-line.
	HCPCS First Modifier Code	The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Second Modifier Code	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Third Modifier Code	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Fourth Modifier Code	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Fifth Modifier Code	The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Part A Procedure Codes	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
		Claim type codes are:
		10=HHA claim
		20=Non swing bed SNF claim
		30=Swing bed SNF claim
		40=Outpatient claim
		50=Hospice claim
		60=Inpatient claim
		61=Inpatient "Full-Encounter" claim

	Claim Value Sequence Number	An arbitrary sequential number that uniquely identifies a procedure code record within the claim.
	Procedure Code	The ICD-9/10 code that indicates the procedure performed during the period covered by the claim.
	Procedure Performed Date	The date the indicated procedure was performed.
	Beneficiary Equitable BIC HICN Number	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level.
	Provider OSCAR Number	A facility’s Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.
	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Part A Diagnosis Codes	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Claim Value Sequence Number	An arbitrary sequential number that uniquely identifies a procedure code record within the claim.
	Claim Product Type Code	Codes classifying the diagnosis category:
		E=Accident diagnosis code
		1=First diagnosis E code
		D=Other diagnosis codes
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
		Claim type codes are:
		10=HHA claim
		20=Non swing bed SNF claim
		30=Swing bed SNF claim
		40=Outpatient claim
		50=Hospice claim
		60=Inpatient claim
		61=Inpatient “Full-Encounter” claim
	Diagnosis Code	The ICD-9/10 diagnosis code identifying the beneficiary’s illness or disability.

	Beneficiary Equitable BIC HICN Number	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary's spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event, using the natural key.
	Provider OSCAR Number	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.
	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
		Also known as "Statement Covers From Date."
	Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.
	Claim Present on Admission Indicator	Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility. Find Present-on-Admission values here:
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Part B Physicians	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Claim Line Number	A sequential number that identifies a specific claim line
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
		Claim type codes are:
		10=HHA claim
		20=Non swing bed SNF claim
		30=Swing bed SNF claim
		40=Outpatient claim
		50=Hospice claim
		60=Inpatient claim
		61=Inpatient "Full-Encounter" claim
	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
	Provider Type Code	Identifies the type of Provider Identifier.

	Rendering Provider FIPS State Code	Identifies the state that the provider providing the service is located in.
	Claim Rendering Federal Provider Specialty Code	Indicates the CMS specialty code associated with the provider of services. CMS used this number to price the service on the line-item.
	Claim Federal Type Service Code	Indicates the type of service (e.g., consultation, surgery) provided to the beneficiary. Types of Service Codes are defined in the Medicare Carrier Manual.
	Claim Line From Date	The date the service associated with the line item began.
	Claim Line Thru Date	The date the service associated with the line item ended.
	HCPCS Code	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
	Claim Line Covered Paid Amount	The amount Medicare reimbursed the provider for covered services associated with the claim-line.
	Claim Primary Payer Code	If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer. This field is also known as the Line Beneficiary Primary Payer Code.
	Diagnosis Code	The ICD-9/10 diagnosis code identifying the beneficiary's principal illness or disability.
	Claim Provider Tax Number	The SSN or Employee Identification Number (EIN) of the provider of the indicated service. This number identifies who receives payment for the indicated service.
	Rendering Provider NPI Number	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI.
	Claim Carrier Payment Denial Code	Indicates to whom payment was made (e.g., physician, beneficiary), or if the claim was denied.
	Claim Line Processing Indicator Code	Indicates whether the service indicated on the claim line was allowed or the reason it was denied.
	Claim Adjustment Type Code	Claim adjustment types (Original, Adjustment, Deleted, Resubmitted, etc.)
	Claim Effective Date	Date the claim was processed and added to the NCH.
	Claim IDR Load Date	When the claim was loaded into the IDR.
	Claim Control Number	A unique number assigned to a claim by the Medicare carrier.
	Beneficiary Equitable BIC HICN Number	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level.
	Claim Line Allowed Charges Amount	The amount Medicare approved for payment to the provider.

	Claim Line Service Unit Quantity	The number of dosage units of medication that were dispensed in this fill.
	HCPCS First Modifier Code	The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Second Modifier Code	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Third Modifier Code	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Fourth Modifier Code	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Fifth Modifier Code	The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	Claim Disposition Code	Information regarding payment actions on the claim. Claim Disposition Codes are: 01=Debit accepted 02=Debit accepted (automatic adjustment) 03=Cancel accepted
	Claim Diagnosis First Code	The first of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
	Claim Diagnosis Second Code	The second of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
	Claim Diagnosis Third Code	The third of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
	Claim Diagnosis Fourth Code	The fourth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
	Claim Diagnosis Fifth Code	The fifth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
	Claim Diagnosis Sixth Code	The sixth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
	Claim Diagnosis Seventh Code	The seventh of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
	Claim Diagnosis Eighth Code	The eighth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Part B DMEs	Current Claim Unique Identifier	A unique identification number assigned to the claim.

	Claim Line Number	A sequential number that identifies a specific claim line
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
		Claim type codes are:
		10=HHA claim
		20=Non swing bed SNF claim
		30=Swing bed SNF claim
		40=Outpatient claim
		50=Hospice claim
		60=Inpatient claim
		61=Inpatient "Full-Encounter" claim
	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
	Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.
	Claim Federal Type Service Code	Indicates the type of service (e.g., consultation, surgery) provided to the beneficiary. Types of Service Codes are defined in the Medicare Carrier Manual.
	Claim Place of Service Code	Indicates the place where the indicated service was provided (e.g., ambulance, school). Places of service are defined in the Medicare Carrier Manual.
	Claim Line From Date	The date the service associated with the line item began.
	Claim Line Thru Date	The date the service associated with the line item ended.
	HCPCS Code	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
	Claim Line Covered Paid Amount	The amount Medicare reimbursed the provider for covered services associated with the claim-line.
	Claim Primary Payer Code	If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer.
	Pay to Provider NPI Number	A number that identifies the provider billing for the indicated service on the claim line. Each provider is assigned its own unique NPI.
	Ordering Provider NPI Number	A number that identifies the provider ordering the indicated service on the claim line. Each provider is assigned its own unique NPI.
	Claim Carrier Payment Denial Code	Indicates to whom payment was made (e.g., physician, beneficiary), or if the claim was denied.
		Find Carrier Payment Denial Codes here:
	Claim Line Processing Indicator Code	Indicates whether the service indicated on the claim line was allowed or the reason it was denied.
	Claim Adjustment Type Code	Claim adjustment types (Original, Adjustment, Deleted, Resubmitted, etc.)

	Claim Effective Date	Date the claim was processed and added to the NCH. Also referred to as the NCH Weekly Processing Date.
	Claim IDR Load Date	When the claim was loaded into the IDR.
	Claim Control Number	A unique number assigned to a claim by the Medicare carrier.
	Beneficiary Equitable BIC HICN Number	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level.
	Claim Line Allowed Charges Amount	The amount Medicare approved for payment to the provider.
	Claim Disposition Code	Information regarding payment actions on the claim.
		Claim Disposition Codes are:
		01=Debit accepted
		02=Debit accepted (automatic adjustment)
		03=Cancel accepted
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. .
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Part D	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Beneficiary HIC Number	A beneficiary identifier.
	NDC Code	A universal unique product identifier for human drugs.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
		Claim type codes are:
		10=HHA claim
		20=Non swing bed SNF claim
		30=Swing bed SNF claim
		40=Outpatient claim
		50=Hospice claim
		60=Inpatient claim
		61=Inpatient “Full-Encounter” claim
	Claim Line From Date	The date the service associated with the line item began.

	Provider Service Identifier Qualifier Code	Indicates the type of number used to identify the pharmacy providing the services:
		01= NPI Number
		06=Unique Physician Identification Number (UPIN)
		07=National Council for Prescription Drug Programs (NCPDP) Number
		08=State License Number
		11=TIN
		99=Other mandatory for Standard Data Format
	Claim Service Provider Generic ID Number	The number associated with the indicated code in the Provider Service Identification Qualifier Code field.
	Claim Dispensing Status Code	Indicates the status of prescription fulfillment.
		Dispensing Codes are:
		P=Partially filled
		C=Completely filled
	Claim Dispense as Written DAW Product Selection Code	Indicates the prescriber's instructions regarding generic substitution or how those instructions were followed.
		DAW Product Selection Codes are:
		0=No product selection indicated
		1=Substitution not allowed by prescriber
		2=Substitution allowed – Patient requested that brand be dispensed
		3=Substitution allowed – Pharmacist selected product dispensed
		4=Substitution allowed – Generic not in stock
		5=Substitution allowed – Brand drug dispensed as generic
		6=Override
		7=Substitution not allowed – Brand drug mandated by law
		8=Substitution allowed – Generic drug not available in marketplace
		9=Other
	Claim Line Service Unit Quantity	The number of dosage units of medication that were dispensed in this fill.
	Claim Line Days' Supply Quantity	The number of days the supply of medication dispensed by the pharmacy will cover.
	Provider Prescribing ID Qualifier Code	The number of days the supply of medication dispensed by the pharmacy will cover.
		Indicates the type of number used to identify the prescribing provider:
		01= NPI Number
		06= UPIN
		07= NCPDP Number

		08=State License Number
		11=TIN
		99=Other mandatory for Standard Data Format
	Claim Prescribing Provider Generic ID Number	The number associated with the indicated code in the Provider Prescribing Service Identification Qualifier Code field.
	Claim Line Beneficiary Payment Amount	The dollar amount paid by the beneficiary that is not reimbursed by a third party (e.g., copayments, coinsurance, deductible or other patient pay amounts).
	Claim Adjustment Type Code	Claim adjustment types (Original, Adjustment, Deleted, Resubmitted, etc.)
	Claim Effective Date	Date the claim was processed and added to the NCH. Also referred to as the NCH Weekly Processing Date.
	Claim IDR Load Date	When the claim was loaded into the IDR.
	Claim Line Prescription Service Reference Number	Identifies a prescription dispensed by a particular service provider on a particular service date.
	Claim Line Prescription Fill Number	Assigned to the current dispensed supply by the pharmacy. It designates the sequential order of the original fill or subsequent refills of a prescription.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Beneficiary Demographics	Beneficiary HICN Number	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level.
	Beneficiary FIPS State Code	Identifies the state where the beneficiary receiving services resides.
	Beneficiary FIPS County Code	Identifies the county where the beneficiary receiving services resides.
	Beneficiary ZIP Code	The beneficiary’s ZIP code as indicated in their Medicare enrollment record.
	Beneficiary Date of Birth	The month, day, and year of the beneficiary’s birth.
	Beneficiary Sex Code	The beneficiary’s sex:
		1=Male
		2=Female

		0=Unknown
	Beneficiary Race Code	The beneficiary's race:
		0=Unknown
		1=White
		2=Black
		3=Other
		4=Asian
		5=Hispanic
		6=North American Native
	Beneficiary Age	The beneficiary's current age, as calculated by subtracting the beneficiary's date of birth from the current date.
	Beneficiary Medicare Status Code	Indicates the reason for a beneficiary's entitlement to Medicare benefits as of a particular date, broken down by the following categories: Old Age & Survivors Insurance (OASI), Disabled, and End Stage Renal Disease (ESRD), and by appropriate combinations of these categories:
		10=Aged without ESRD
		11=Aged with ESRD
		20=Disabled without ESRD
		21=Disabled with ESRD
		31=ESRD only
	Beneficiary Dual Status Code	Identifies the most recent entitlement status of beneficiaries eligible for a program(s) in addition to Medicare (e.g., Medicaid).
	Beneficiary Death Date	The month, day, and year of a beneficiary's death.
	Date beneficiary enrolled in Hospice	The date the beneficiary enrolled in Hospice.
	Date beneficiary ended Hospice	The date the beneficiary is-enrolled in hospice.
	Beneficiary First Name	The first name of the beneficiary.
	Beneficiary Middle Name	The middle name of the beneficiary.
	Beneficiary Last Name	The last name of the beneficiary.
	Beneficiary Original Entitlement Reason Code	Original Reason for the beneficiary's entitlement to Medicare Benefits.
		Values are:
		0 Beneficiary insured due to age (OASI);
		1 Beneficiary insured due to disability;

		2 Beneficiary insured due to End Stage; Renal Disease (ESRD);
		3 Beneficiary insured due to disability and current ESRD.
		4. None of the above
	Beneficiary Entitlement Buy In Indicator	Indicates for each month of the Denominator reference year, the entitlement of the beneficiary to Medicare Part A, Medicare Part B, or Medicare Parts A and B both, as well as whether or not the beneficiary's state of residence was liable and paid for the beneficiary's Medicare Part B monthly premiums.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Beneficiary XREF	Current HIC Number	A beneficiary identifier.
	Previous HIC Number	The HICN that appears in this field is the beneficiary's previous HICN.
	Previous HICN Effective Date	The date the previous HICN became active.
	Previous HICN Obsolete Date	The date the previous HICN ceased to be active.
	Beneficiary Railroad Board Number	The external (to Medicare) HICN for beneficiaries that are RRB members.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Summary Statistics	ACO Identifier	The unique identifier of an ACO
	File Type	The CCLF File Type
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
	File Description	The description of the CCLF File
	Total Records Count	The total number of records in the file

	Record Length	The length of the record for the file
	File Name	The name the CCLF extract file that was sent to be swept by the EFT process

ID	Code	Data File Description
372481	CCRAF	CCRAF - CM/CMMI CENTRAL REPOSITORY OF ALIGNMENT FILES
372482	CCRAFP	CCRAFP - CM/CMMI CENTRAL REPOSITORY PAYMENT FILE
251250	CME	CME - COMMON MEDICARE ENROLLMENT
325418	EDB	EDB - ENROLLMENT DATA BASE
371426	HCC	HCC - HEALTH CARE CHARACTERISTICS RISK SCORES
340484	MBSF	MBSF - MASTER BENEFICIARY SUMMARY FILE
368575	MDD	MDD - MASTER DATA MANAGEMENT
325419	PDE	PDE - PART D - PRESCRIPTION DRUG EVENT DATA
366866	PQRSSD	PQRSSD - PQRS SUBMISSION DATA
--	--	Medicare Claims data (Part A/Part B)

Appendix I: The Green Mountain Care Board Attestation and Data Specification Worksheet

HIPAA-Covered Disclosure Request Attestation

The Green Mountain Care Board (GMCB) requests the CMS data listed in the Data Specification Worksheet below and makes the following assertions regarding its ability to meet the HIPAA requirements for receiving such data:

- The GMCB affirms that it is a "health oversight agency" as defined in 45 C.F.R. § 164.501 and represented in Section 15 (Data Sharing) of this Agreement.

The GMCB is seeking protected health information (PHI), as defined in 45 C.F.R. § 160.103 (select one):

- For its own "oversight activities" as specified in the HIPAA Privacy Rule at 45 C.F.R. § 164.512(d).
- Other: Please attach a description of the intended use.

The GMCB requests (select one):

- For the Medicare FFS Beneficiaries who reside in Vermont, GMCB requests ,GMCB request: (i) three years of historical data files for each performance year of the model consisting of the data elements identified in the Data Specification Worksheet for Initiative Beneficiaries; and (ii) monthly claims data files for all Initiative Beneficiaries for the data elements identified in the Data Specification Worksheet, from the following CMS Integrated Data Repository (IDR) data files:
    - CCRAF - CM/CMMI CENTRAL REPOSITORY OF ALIGNMENT FILES
    - EDB - ENROLLMENT DATA BASE,
    - HCC - HEALTH CARE CHARACTERISTICS RISK SCORE
    - MBSF - MASTER BENEFICIARY SUMMARY FILE
    - MDD - MASTER DATA MANAGEMENT,
    - PQRSSD - PQRS SUBMISSION DATA
    - IDR Medicare Part A and Part B claims and eligibility data (NOTE: file name TBD)
    - IDR Medicare Part D data (DRX09 - IDR RESTRICTED ACCESS TO LIMITED MEDICARE PART D CLAIM DATA (NO FINANCIAL PAYMENT COLUMNS).)
- Other: Please attach a detailed description of the data requested.

The data requested is (select one):

- **The "minimum necessary" (as defined at 45 C.F.R. § 164.502(b)) to carry out the oversight activities described above.**

- Other: Please attach a description of how (if applicable) the data requested exceeds what is needed to carry out the work described above.

The GMCB's data custodian for the requested data are as follows:

1. Name
   Organization and Address
   Email
   Phone Number

Data Specification Worksheet

Data Element Source	Data Element	Data Element Description
Part A Claims	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Provider OSCAR Number	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 10=HHA claim 20=Non swing bed SNF claim 30=Swing bed SNF claim 40=Outpatient claim 50=Hospice claim 60=Inpatient claim 61=Inpatient "Full-Encounter" claim
	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
	Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.
	Claim Bill Facility Type Code	The first digit of the type of bill (TOB1) is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are: 1=Hospital 2=SNF 3=HHA 4=Religious non-medical (hospital) 5=Religious non-medical (extended care) 6=Intermediate care 7=Clinic or hospital-based renal dialysis facility 8=Specialty facility or Ambulatory Surgical Center (ASC) surgery 9=Reserved
	Claim Bill Facility Type Code	The first digit of the type of bill (TOB1) is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF).
		Claim Facility Type Codes are:
		1=Hospital

		2=SNF
		3=HHA
		4=Religious non-medical (hospital)
		5=Religious non-medical (extended care)
		6=Intermediate care
		7=Clinic or hospital-based renal dialysis facility
		8=Specialty facility or Ambulatory Surgical Center (ASC) surgery
		9=Reserved
	Claim Bill Classification Code	The second digit of the type of bill (TOB2) is used to indicate with greater specificity where the service was provided (e.g., a department within a hospital).
	Principal Diagnosis Code	The International Classification of Diseases (ICD)-9/10 diagnosis code identifies the beneficiary's principal illness or disability.
	Admitting Diagnosis Code	The ICD-9/10 diagnosis code identifies the illness or disability for which the beneficiary was admitted.
	Claim Medicare Non Payment Reason Code	Indicates the reason payment on an institutional claim is denied.
	Claim Payment Amount	Amount that Medicare paid on the claim.
	Claim NCH Primary Payer Code	If a payer other than Medicare has primary responsibility for payment of the beneficiary's health insurance bills, this code indicates the responsible primary payer.
	Federal Information Processing Standards FIPS State Code	Identifies the state where the facility providing services is located.
	Beneficiary Patient Status Code	Indicates the patient's discharge status as of the Claim Through Date. For example, it may indicate where a patient was discharged to (e.g., home, another facility) or the circumstances of a discharge (e.g., against medical advice, or patient death).
	Diagnosis Related Group Code	Indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes.
	Claim Outpatient Service Type Code	Indicates the type and priority of outpatient service.
		Claim Outpatient Service Type Codes are:
		0=Blank
		1=Emergency
		2=Urgent
		3=Elective
		5-8=Reserved
		9=Unknown

	Facility Provider NPI Number	Identifies the facility associated with the claim. Each facility is assigned its own unique NPI.
	Operating Provider NPI Number	Identifies the operating provider associated with the claim. Each provider is assigned its own unique NPI.
	Attending Provider NPI Number	Identifies the attending provider associated with the claim. Each provider is assigned its own unique NPI.
	Other Provider NPI Number	Identifies the other providers associated with the claim. Each provider is assigned its own unique NPI.
	Claim Adjustment Type Code	Claim adjustment types (Original, Adjustment, Deleted, Resubmitted, etc.)
	Claim Effective Date	Date the claim was processed and added to the NCH. Also referred to as the NCH Weekly Processing Date.
	Claim IDR Load Date	When the claim was loaded into the IDR.
	Beneficiary Equitable BIC HICN Number	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level.
	Claim Admission Type Code	Indicates the type and priority of inpatient services.
		Claim Admission Type Codes are:
		0=Blank
		1=Emergency
		2=Urgent
		3=Elective
		4=Newborn
		5=Trauma Center
		6-8=Reserved
		9=Unknown
	Claim Admission Source Code	Indicates the source of the beneficiary's referral for admission or visit (e.g., a physician or another facility).
		Find Admission Source Codes here: http://www.resdac.org/cms-data/variables/Claim-Source-Inpatient-Admission-Code
	Claim Bill Frequency Code	The third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided).
		Find Claim Frequency Codes here: http://www.resdac.org/cms-data/variables/Claim-Frequency-Code.
	Claim Query Code	Indicates the type of claim record being processed with respect to payment (e.g., debit/credit indicator or interim/final indicator).
		Claim Query Codes are:
		0=Credit adjustment
		1=Interim bill
		2=HHA benefits exhausted

		3=Final bill
		4=Discharge notice
		5=Debit adjustment
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Part A Claims Revenue Center Details	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Claim Line Number	A sequential number that identifies a specific claim line
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
		Claim type codes are:
		10=HHA claim
		20=Non swing bed SNF claim
		30=Swing bed SNF claim
		40=Outpatient claim
		50=Hospice claim
		60=Inpatient claim
		61=Inpatient “Full-Encounter” claim
	Claim Line From Date	The date the service associated with the line item began.
	Claim Line Thru Date	The date the service associated with the line item ended.
	Product Revenue Center Code	The number a provider assigns to the cost center to which a particular charge is billed (e.g., accommodations or supplies).
	Claim Line Institutional Revenue Center Date	The date that applies to the service associated with the Revenue Center code.
	HCPCS Code	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
	Beneficiary Equitable BIC HICN Number	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level.

	Provider OSCAR Number	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.
	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
	Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.
	Claim Line Service Unit Quantity	The number of dosage units of medication that were dispensed in this fill.
	Claim Line Covered Paid Amount	The amount Medicare reimbursed the provider for covered services associated with the claim-line.
	HCPCS First Modifier Code	The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Second Modifier Code	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Third Modifier Code	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Fourth Modifier Code	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Fifth Modifier Code	The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Part A Procedure Codes	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
		Claim type codes are:
		10=HHA claim
		20=Non swing bed SNF claim
		30=Swing bed SNF claim
		40=Outpatient claim
		50=Hospice claim
		60=Inpatient claim
		61=Inpatient "Full-Encounter" claim

	Claim Value Sequence Number	An arbitrary sequential number that uniquely identifies a procedure code record within the claim.
	Procedure Code	The ICD-9/10 code that indicates the procedure performed during the period covered by the claim.
	Procedure Performed Date	The date the indicated procedure was performed.
	Beneficiary Equitable BIC HICN Number	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level.
	Provider OSCAR Number	A facility’s Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.
	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Part A Diagnosis Codes	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Claim Value Sequence Number	An arbitrary sequential number that uniquely identifies a procedure code record within the claim.
	Claim Product Type Code	Codes classifying the diagnosis category:
		E=Accident diagnosis code
		1=First diagnosis E code
		D=Other diagnosis codes
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
		Claim type codes are:
		10=HHA claim
		20=Non swing bed SNF claim
		30=Swing bed SNF claim
		40=Outpatient claim
		50=Hospice claim
		60=Inpatient claim
		61=Inpatient “Full-Encounter” claim
	Diagnosis Code	The ICD-9/10 diagnosis code identifying the beneficiary’s illness or disability.

	Beneficiary Equitable BIC HICN Number	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary's spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event, using the natural key.
	Provider OSCAR Number	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.
	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
		Also known as "Statement Covers From Date."
	Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.
	Claim Present on Admission Indicator	Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility. Find Present-on-Admission values here:
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Part B Physicians	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Claim Line Number	A sequential number that identifies a specific claim line
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
		Claim type codes are:
		10=HHA claim
		20=Non swing bed SNF claim
		30=Swing bed SNF claim
		40=Outpatient claim
		50=Hospice claim
		60=Inpatient claim
		61=Inpatient "Full-Encounter" claim
	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
	Provider Type Code	Identifies the type of Provider Identifier.

	Rendering Provider FIPS State Code	Identifies the state that the provider providing the service is located in.
	Claim Rendering Federal Provider Specialty Code	Indicates the CMS specialty code associated with the provider of services. CMS used this number to price the service on the line-item.
	Claim Federal Type Service Code	Indicates the type of service (e.g., consultation, surgery) provided to the beneficiary. Types of Service Codes are defined in the Medicare Carrier Manual.
	Claim Line From Date	The date the service associated with the line item began.
	Claim Line Thru Date	The date the service associated with the line item ended.
	HCPCS Code	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
	Claim Line Covered Paid Amount	The amount Medicare reimbursed the provider for covered services associated with the claim-line.
	Claim Primary Payer Code	If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer. This field is also known as the Line Beneficiary Primary Payer Code.
	Diagnosis Code	The ICD-9/10 diagnosis code identifying the beneficiary's principal illness or disability.
	Claim Provider Tax Number	The SSN or Employee Identification Number (EIN) of the provider of the indicated service. This number identifies who receives payment for the indicated service.
	Rendering Provider NPI Number	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI.
	Claim Carrier Payment Denial Code	Indicates to whom payment was made (e.g., physician, beneficiary), or if the claim was denied.
	Claim Line Processing Indicator Code	Indicates whether the service indicated on the claim line was allowed or the reason it was denied.
	Claim Adjustment Type Code	Claim adjustment types (Original, Adjustment, Deleted, Resubmitted, etc.)
	Claim Effective Date	Date the claim was processed and added to the NCH.
	Claim IDR Load Date	When the claim was loaded into the IDR.
	Claim Control Number	A unique number assigned to a claim by the Medicare carrier.
	Beneficiary Equitable BIC HICN Number	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level.
	Claim Line Allowed Charges Amount	The amount Medicare approved for payment to the provider.

	Claim Line Service Unit Quantity	The number of dosage units of medication that were dispensed in this fill.
	HCPCS First Modifier Code	The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Second Modifier Code	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Third Modifier Code	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Fourth Modifier Code	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Fifth Modifier Code	The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	Claim Disposition Code	Information regarding payment actions on the claim. Claim Disposition Codes are: 01=Debit accepted 02=Debit accepted (automatic adjustment) 03=Cancel accepted
	Claim Diagnosis First Code	The first of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
	Claim Diagnosis Second Code	The second of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
	Claim Diagnosis Third Code	The third of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
	Claim Diagnosis Fourth Code	The fourth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
	Claim Diagnosis Fifth Code	The fifth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
	Claim Diagnosis Sixth Code	The sixth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
	Claim Diagnosis Seventh Code	The seventh of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
	Claim Diagnosis Eighth Code	The eighth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Part B DMEs	Current Claim Unique Identifier	A unique identification number assigned to the claim.

	Claim Line Number	A sequential number that identifies a specific claim line
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
		Claim type codes are:
		10=HHA claim
		20=Non swing bed SNF claim
		30=Swing bed SNF claim
		40=Outpatient claim
		50=Hospice claim
		60=Inpatient claim
		61=Inpatient "Full-Encounter" claim
	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
	Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.
	Claim Federal Type Service Code	Indicates the type of service (e.g., consultation, surgery) provided to the beneficiary. Types of Service Codes are defined in the Medicare Carrier Manual.
	Claim Place of Service Code	Indicates the place where the indicated service was provided (e.g., ambulance, school). Places of service are defined in the Medicare Carrier Manual.
	Claim Line From Date	The date the service associated with the line item began.
	Claim Line Thru Date	The date the service associated with the line item ended.
	HCPCS Code	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
	Claim Line Covered Paid Amount	The amount Medicare reimbursed the provider for covered services associated with the claim-line.
	Claim Primary Payer Code	If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer.
	Pay to Provider NPI Number	A number that identifies the provider billing for the indicated service on the claim line. Each provider is assigned its own unique NPI.
	Ordering Provider NPI Number	A number that identifies the provider ordering the indicated service on the claim line. Each provider is assigned its own unique NPI.
	Claim Carrier Payment Denial Code	Indicates to whom payment was made (e.g., physician, beneficiary), or if the claim was denied.
		Find Carrier Payment Denial Codes here:
	Claim Line Processing Indicator Code	Indicates whether the service indicated on the claim line was allowed or the reason it was denied.
	Claim Adjustment Type Code	Claim adjustment types (Original, Adjustment, Deleted, Resubmitted, etc.)

	Claim Effective Date	Date the claim was processed and added to the NCH. Also referred to as the NCH Weekly Processing Date.
	Claim IDR Load Date	When the claim was loaded into the IDR.
	Claim Control Number	A unique number assigned to a claim by the Medicare carrier.
	Beneficiary Equitable BIC HICN Number	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level.
	Claim Line Allowed Charges Amount	The amount Medicare approved for payment to the provider.
	Claim Disposition Code	Information regarding payment actions on the claim.
		Claim Disposition Codes are:
		01=Debit accepted
		02=Debit accepted (automatic adjustment)
		03=Cancel accepted
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. .
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Part D	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Beneficiary HIC Number	A beneficiary identifier.
	NDC Code	A universal unique product identifier for human drugs.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
		Claim type codes are:
		10=HHA claim
		20=Non swing bed SNF claim
		30=Swing bed SNF claim
		40=Outpatient claim
		50=Hospice claim
		60=Inpatient claim
		61=Inpatient “Full-Encounter” claim
	Claim Line From Date	The date the service associated with the line item began.

	Provider Service Identifier Qualifier Code	Indicates the type of number used to identify the pharmacy providing the services:
		01= NPI Number
		06=Unique Physician Identification Number (UPIN)
		07=National Council for Prescription Drug Programs (NCPDP) Number
		08=State License Number
		11=TIN
		99=Other mandatory for Standard Data Format
	Claim Service Provider Generic ID Number	The number associated with the indicated code in the Provider Service Identification Qualifier Code field.
	Claim Dispensing Status Code	Indicates the status of prescription fulfillment.
		Dispensing Codes are:
		P=Partially filled
		C=Completely filled
	Claim Dispense as Written DAW Product Selection Code	Indicates the prescriber's instructions regarding generic substitution or how those instructions were followed.
		DAW Product Selection Codes are:
		0=No product selection indicated
		1=Substitution not allowed by prescriber
		2=Substitution allowed – Patient requested that brand be dispensed
		3=Substitution allowed – Pharmacist selected product dispensed
		4=Substitution allowed – Generic not in stock
		5=Substitution allowed – Brand drug dispensed as generic
		6=Override
		7=Substitution not allowed – Brand drug mandated by law
		8=Substitution allowed – Generic drug not available in marketplace
		9=Other
	Claim Line Service Unit Quantity	The number of dosage units of medication that were dispensed in this fill.
	Claim Line Days' Supply Quantity	The number of days the supply of medication dispensed by the pharmacy will cover.
	Provider Prescribing ID Qualifier Code	The number of days the supply of medication dispensed by the pharmacy will cover.
		Indicates the type of number used to identify the prescribing provider:
		01= NPI Number
		06= UPIN
		07= NCPDP Number

		08=State License Number
		11=TIN
		99=Other mandatory for Standard Data Format
	Claim Prescribing Provider Generic ID Number	The number associated with the indicated code in the Provider Prescribing Service Identification Qualifier Code field.
	Claim Line Beneficiary Payment Amount	The dollar amount paid by the beneficiary that is not reimbursed by a third party (e.g., copayments, coinsurance, deductible or other patient pay amounts).
	Claim Adjustment Type Code	Claim adjustment types (Original, Adjustment, Deleted, Resubmitted, etc.)
	Claim Effective Date	Date the claim was processed and added to the NCH. Also referred to as the NCH Weekly Processing Date.
	Claim IDR Load Date	When the claim was loaded into the IDR.
	Claim Line Prescription Service Reference Number	Identifies a prescription dispensed by a particular service provider on a particular service date.
	Claim Line Prescription Fill Number	Assigned to the current dispensed supply by the pharmacy. It designates the sequential order of the original fill or subsequent refills of a prescription.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Beneficiary Demographics	Beneficiary HICN Number	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level.
	Beneficiary FIPS State Code	Identifies the state where the beneficiary receiving services resides.
	Beneficiary FIPS County Code	Identifies the county where the beneficiary receiving services resides.
	Beneficiary ZIP Code	The beneficiary’s ZIP code as indicated in their Medicare enrollment record.
	Beneficiary Date of Birth	The month, day, and year of the beneficiary’s birth.
	Beneficiary Sex Code	The beneficiary’s sex:
		1=Male
		2=Female

		0=Unknown
	Beneficiary Race Code	The beneficiary's race:
		0=Unknown
		1=White
		2=Black
		3=Other
		4=Asian
		5=Hispanic
		6=North American Native
	Beneficiary Age	The beneficiary's current age, as calculated by subtracting the beneficiary's date of birth from the current date.
	Beneficiary Medicare Status Code	Indicates the reason for a beneficiary's entitlement to Medicare benefits as of a particular date, broken down by the following categories: Old Age & Survivors Insurance (OASI), Disabled, and End Stage Renal Disease (ESRD), and by appropriate combinations of these categories:
		10=Aged without ESRD
		11=Aged with ESRD
		20=Disabled without ESRD
		21=Disabled with ESRD
		31=ESRD only
	Beneficiary Dual Status Code	Identifies the most recent entitlement status of beneficiaries eligible for a program(s) in addition to Medicare (e.g., Medicaid).
	Beneficiary Death Date	The month, day, and year of a beneficiary's death.
	Date beneficiary enrolled in Hospice	The date the beneficiary enrolled in Hospice.
	Date beneficiary ended Hospice	The date the beneficiary is-enrolled in hospice.
	Beneficiary First Name	The first name of the beneficiary.
	Beneficiary Middle Name	The middle name of the beneficiary.
	Beneficiary Last Name	The last name of the beneficiary.
	Beneficiary Original Entitlement Reason Code	Original Reason for the beneficiary's entitlement to Medicare Benefits.
		Values are:
		0 Beneficiary insured due to age (OASI);
		1 Beneficiary insured due to disability;

		2 Beneficiary insured due to End Stage; Renal Disease (ESRD);
		3 Beneficiary insured due to disability and current ESRD.
		4. None of the above
	Beneficiary Entitlement Buy In Indicator	Indicates for each month of the Denominator reference year, the entitlement of the beneficiary to Medicare Part A, Medicare Part B, or Medicare Parts A and B both, as well as whether or not the beneficiary's state of residence was liable and paid for the beneficiary's Medicare Part B monthly premiums.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Beneficiary XREF	Current HIC Number	A beneficiary identifier.
	Previous HIC Number	The HICN that appears in this field is the beneficiary's previous HICN.
	Previous HICN Effective Date	The date the previous HICN became active.
	Previous HICN Obsolete Date	The date the previous HICN ceased to be active.
	Beneficiary Railroad Board Number	The external (to Medicare) HICN for beneficiaries that are RRB members.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Summary Statistics	ACO Identifier	The unique identifier of an ACO
	File Type	The CCLF File Type
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
	File Description	The description of the CCLF File
	Total Records Count	The total number of records in the file

	Record Length	The length of the record for the file
	File Name	The name the CCLF extract file that was sent to be swept by the EFT process

ID	Code	Data File Description
372481	CCRAF	CCRAF - CM/CMMI CENTRAL REPOSITORY OF ALIGNMENT FILES
372482	CCRAFP	CCRAFP - CM/CMMI CENTRAL REPOSITORY PAYMENT FILE
251250	CME	CME - COMMON MEDICARE ENROLLMENT
325418	EDB	EDB - ENROLLMENT DATA BASE
371426	HCC	HCC - HEALTH CARE CHARACTERISTICS RISK SCORES
340484	MBSF	MBSF - MASTER BENEFICIARY SUMMARY FILE
368575	MDD	MDD - MASTER DATA MANAGEMENT
325419	PDE	PDE - PART D - PRESCRIPTION DRUG EVENT DATA
366866	PQRSSD	PQRSSD - PQRS SUBMISSION DATA
--	--	Medicare Claims data (Part A/Part B)