

MARYLAND TOTAL COST OF CARE MODEL STATE AGREEMENT

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MARYLAND TOTAL COST OF CARE MODEL STATE AGREEMENT

This Maryland Total Cost of Care Model State Agreement (“**Agreement**”) is between the Centers for Medicare & Medicaid Services (“**CMS**”) and the Governor of Maryland, the Maryland Department of Health (“**MDH**”), and the Health Services Cost Review Commission (“**HSCRC**”) (collectively, the “**State**”). 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. The MDH oversees the Maryland health care system generally and promotes and guides the development of physical and behavioral health care for the State. The MDH will assist CMS in the implementation of the Maryland Primary Care Program (“**MDPCP**”) to provide better patient-centered care for Maryland residents. The HSCRC is an independent Maryland state agency, authorized by Maryland state law to oversee the State’s hospital health care system by setting reasonable reimbursement rates payable by Medicare and Maryland Payers that enable hospitals to provide their services effectively and efficiently. Since its inception, the primary mission of the HSCRC has been to contain costs while improving quality of care and enhancing access to needed hospital services.

CMS is implementing the Maryland Total Cost of Care Model (the “**Model**”) 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. Under this Model, CMS and the State will test whether State-wide health care delivery transformation, in conjunction with Population-Based Payments, improves population health and care outcomes for individuals, while controlling the growth of Medicare Total Cost of Care (“**TCOC**”).

The Parties hereby agree as follows:

TERMS OF AGREEMENT

1. Definitions.

“**Days**” means calendar days unless otherwise specified.

“**Exogenous Factors**” means factors outside the State’s control, including factors

unrelated to the Model (e.g., changes in health insurance coverage; the construction of a new hospital facility; the rapid adoption of a new technology; investments in care redesign at an accelerated pace; changes in law or regulations; localized health, environmental, or economic shocks; or localized civil disorder), as well as delays by CMS in providing Medicare expenditure data, reviewing Model Program Proposals, or performing other deliverables required of CMS under the terms of this Agreement that materially and adversely affect the State's ability to meet the Model Financial Targets described in Section 6.

“Maryland Medicare Beneficiary” means a Medicare FFS Beneficiary who resides in Maryland.

“Maryland Medicare TCOC per Beneficiary” means the annual TCOC for each Maryland Medicare Beneficiary, as calculated in accordance with Appendix C of this Agreement.

“Maryland Payers” means the health care purchasers, including Maryland Medicaid, which the State requires to reimburse Regulated Maryland Hospitals on the basis of rates established by the HSCRC. The term Maryland Payers shall not be construed to refer to the Medicare program.

“Medicare Fee-for-Service (FFS)” means Medicare Part A and Part B and does not include Medicare Part C (Medicare Advantage) or Part D.

“Medicare FFS Beneficiary” means an individual enrolled in Medicare Part A or Medicare Part B, but who is not enrolled in Medicare Part C (Medicare Advantage).

“Medicare Performance Adjustment” or “MPA” means the percentage by which a Regulated Maryland Hospital's Medicare FFS payments will be adjusted by CMS in accordance with Section 8.c.iii.2.

“Model Program” means a component initiative of the Model test. The term Model Program refers to the Hospital Payment Program described in Section 8, the Care Redesign Program (“**CRP**”) described in Section 9, the Maryland Primary Care Program (“**MDPCP**”) described in Section 10, and any additional programs proposed by the State and implemented by CMS in accordance with Section 11.

“Model Year” or “MY” means a calendar year during the Agreement Term, as that term is defined in Section 2.b.

“National Medicare TCOC per Beneficiary” means the annual TCOC for each Medicare FFS Beneficiary, as calculated in accordance with Appendix C of this Agreement.

“Rate Year” means the period from July of one calendar year through June of the next.

“Regulated Maryland Hospital” means a hospital located in Maryland for which payments are regulated by the State for all payers, including Medicare. A list of Regulated Maryland Hospitals appears in Appendix A of the Agreement, as updated from time to time.

“Regulated Revenue” means the full subset of revenue charged by Regulated Maryland Hospitals for which the State has the legal authority to set payment rates.

“Total Cost of Care” or **“TCOC”** means the aggregate Medicare FFS costs for all items and services, or a specified subset thereof, furnished to Medicare FFS Beneficiaries.

CRP DEFINITIONS

“Allowable CRP Interventions” means the CRP Interventions set forth in a CRP Hospital’s Approved Track Implementation Protocol.

“Approved Track Implementation Protocol” means a Track Implementation Protocol that has been completed by the CRP Hospital and approved by the HSCRC and CMS in accordance with the CRP Participation Agreement.

“Care Partner” means a provider or supplier who (1) is enrolled in Medicare; (2) provides items and services to Maryland Medicare Beneficiaries; (3) satisfies any applicable Care Partner Qualifications; (4) is identified on the Care Partner List; and (5) has a written Care Partner Arrangement with the CRP Hospital.

“Care Partner Arrangement” means a financial arrangement between the CRP Hospital and a Care Partner pursuant to which the Care Partner participates in a CRP Track and may receive Incentive Payments, Intervention Resources, or both, in exchange for performing Allowable CRP Interventions.

“Care Partner List” means the list, as may be updated, of Care Partners and Downstream Care Partners approved by CMS to participate in the CRP.

“Care Partner Qualifications” means additional criteria, as set forth in the relevant Track Implementation Protocol, with which a Care Partner must comply in order to participate in a CRP Track and receive Incentive Payments, Intervention Resources, or both and with which a Downstream Care Partner must comply in order to participate in a CRP Track and receive Downstream Incentive Payments.

“CRP” stands for the “care redesign program” established by CMS and the State

pursuant to this Agreement and the CRP Participation Agreement.

“CRP Calendar” has the meaning set forth in Section 9.b.ix of this Agreement.

“CRP Hospital” means a Regulated Maryland Hospital that is a party to a CRP Participation Agreement.

“CRP Intervention” means an activity or process, available under a CRP Track and set forth in the relevant Track Implementation Protocol, that is designed to improve or support one or more of the following: (1) care management and care coordination; (2) population health; (3) access to care; (4) risk stratification; (5) evidence-based care; (6) patient experience; (7) shared-decision making; (8) the reduction of medical error rates; or (9) operational efficiency.

“CRP Monitoring Plan” means the plan developed by the HSCRC in accordance with Section 9.h of this Agreement to monitor compliance by CRP Hospitals with the terms of the CRP Participation Agreement and each CRP Hospital’s Approved Track Implementation Protocols.

“CRP Participation Agreement” means the agreement executed by CMS, the HSCRC, the MDH, and a Regulated Maryland Hospital, that governs the hospital’s participation in the CRP.

“CRP Performance Period” means the period of time when one or more CRP Tracks is in effect as defined in the CRP Participation Agreement.

“CRP Report” means the report the CRP Hospital submits to the HSCRC and CMS, in accordance with the CRP Participation Agreement.

“CRP Track” means a care redesign initiative developed by the Parties and implemented by the CRP Hospital with the assistance of Care Partners.

“Downstream Care Partner” means an individual who is a PGP Member of a PGP Care Partner who (1) is enrolled in Medicare; (2) provides items and services to Maryland Medicare Beneficiaries; (3) satisfies any applicable Care Partner Qualifications; (4) is identified on the Care Partner List; and (5) has a Downstream Care Partner Arrangement with its PGP Care Partner.

“Downstream Care Partner Arrangement” means a financial arrangement between a PGP Care Partner and a Downstream Care Partner pursuant to which the Downstream Care Partner participates in a CRP Track and receives Downstream Incentive Payments in exchange for performing Allowable CRP Interventions.

“Downstream Incentive Payment” means a monetary payment made by the PGP Care Partner to a Downstream Care Partner solely for Allowable CRP Interventions actually performed on a Medicare FFS Beneficiary by the Downstream Care Partner during a specified period of time not to exceed a CRP Performance Period.

“Incentive Payment” means a monetary payment made by the CRP Hospital directly to a Care Partner solely for Allowable CRP Interventions actually performed on a Medicare FFS Beneficiary by the Care Partner during a specific period of time not to exceed a CRP Performance Period.

“Incentive Payment Methodology” has the meaning set forth in Section 9.e of this Agreement.

“Incentive Payment Pool” means the aggregate amount of Incentive Payments, as determined by the HSCRC in accordance with Section 9.g of this Agreement that the CRP Hospital may pay to all of its Care Partners in a CRP Track for the relevant CRP Performance Period.

“Intervention Resource” means nonmonetary remuneration furnished by the CRP Hospital directly to a Care Partner for the purpose of assisting the Care Partner (or, in the case of a Care Partner that is a PGP, its PGP Members) in performing care management and the CRP Interventions for Medicare FFS Beneficiaries.

“Intervention Resource Allocation” means a monetary amount, as determined by the HSCRC in accordance with Section 9.f of this Agreement that the CRP Hospital may use to fund Intervention Resources during a CRP Performance Period.

“NPP” stands for “non-physician practitioner.”

“PAU” stands for “potentially avoidable utilization” and means the utilization of health care items and services, including care furnished to treat complications during a hospital admission, which may be unnecessary or is avoidable through improved efficiency, care coordination, or effective community-based care.

“PAU Savings” means the Medicare cost savings that the CRP Hospital is deemed to have achieved for a CRP Track through the reduction of PAU and other savings that the CRP Hospital achieved as a result of the reduced PAU, as determined by the HSCRC in accordance with Section 9.d of this Agreement.

“PGP” stands for “physician group practice.”

“PGP Member” or **“Member of the PGP”** means a physician or NPP who is an owner or employee of a PGP or has entered into a contract with a PGP, and who has

reassigned to the PGP his or her right to receive Medicare payment.

“Track Implementation Protocol” means a form that has been approved by CMS, in accordance with this Agreement, that is designed to be completed by a Regulated Maryland Hospital and to set forth the Regulated Maryland Hospital’s plan for implementing a CRP Track.

“Track Implementation Template” means the document in which the HSCRC sets forth the design and requirements for a CRP Track, including the information identified in Section 9.b.iii of this Agreement.

2. Agreement Term.

- a. **Effective Date.** The effective date of this Agreement (the **“Effective Date”**) is the date this Agreement is signed by the last Party to sign it (as indicated by the date associated with that Party’s signature).
- b. **Term of the Agreement.** The term of the Agreement (the **“Agreement Term”**) begins on the Effective Date, includes the Performance Period of the Model (as defined in Section 2.c) and, unless the Agreement is sooner terminated by either party pursuant to Section 12.f, a subsequent Transition Period (as defined in Section 2.d.i or 2.d.ii, as applicable).
- c. **Performance Period of the Model.**
 - i. **Performance Period of the Model Defined.** The period of performance under the Model (**“Performance Period of the Model”**) consists of the following eight (8) Model Years:

Model Year 1 (MY1): January 1, 2019 – December 31, 2019

Model Year 2 (MY2): January 1, 2020 – December 31, 2020

Model Year 3 (MY3): January 1, 2021 – December 31, 2021

Model Year 4 (MY4): January 1, 2022 – December 31, 2022

Model Year 5 (MY5): January 1, 2023 – December 31, 2023

Model Year 6 (MY6): January 1, 2024 – December 31, 2024

Model Year 7 (MY7): January 1, 2025 – December 31, 2025

Model Year 8 (MY8): January 1, 2026 – December 31, 2026

- ii. **Performance Period Activities.**

- 1. For each Model Year during the Performance Period of the Model:

- a. The State must meet the applicable Model Financial Targets, each defined in Section 6.
 - b. CMS will assess the State’s performance in meeting the applicable Model Financial Targets in accordance with Section 6 and Appendix C of this Agreement and will advise the State of the State’s performance in meeting such targets by May 1 of the following calendar year.
 - c. If the State fails to meet the applicable Annual Savings Target for a given Model Year by more than \$30 million during the Performance Period of the Model, it will be either a Triggering Event or Other Event as such terms are defined in Section 12.
2. By the end of MY6 (2024), CMS will decide whether to expand the Model pursuant to Section 1115A(c) of the Act. CMS will only expand the Model if CMS and the State have agreed upon a Compounded Savings Target in accordance with Section 6.d. If CMS decides to expand the Model, CMS will issue regulations and take any other actions needed to implement the model expansion beginning on or before January 1, 2029.
 3. If CMS decides not to expand the Model, the State may propose a new model test to CMS no later than January 1, 2026 (beginning of MY8). By December 31, 2026 (end of MY8), CMS will approve, approve with modifications, or reject the State’s proposal for a new model test. Any new model test proposed by the State and approved by CMS will be implemented on or before January 1, 2029.

d. Transition Period.

- i. **Transition Period Defined.** The period of transition of the Model (“**Transition Period**”) consists of two (2) Model Years. The Model Years of the Transition Period will align with the following calendar years except as provided in Section 2.d.ii:

Model Year 9 (MY9): January 1, 2027 – December 31, 2027

Model Year 10 (MY10): January 1, 2028 – December 31, 2028

- ii. **Early Trigger of Transition Period.** If the Performance Period of the Model is terminated pursuant to Section 12.f prior to December 31,

2026, the two (2) Model Years of the Transition Period will align with the two (2) calendar years that begin on the effective date of such termination.

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

1. If the Model is expanded as described in Section 2.c.ii.2 or if the State and CMS agree upon a new model test as described in Section 2.c.ii.3, CMS and the State will prepare to implement the expanded Model or new model test and the State will remain subject to the Compounded Savings Target described in Section 6.d until the start date of the model expansion or new model test.
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, 2026, as described in Section 2.d.ii, Regulated Maryland 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.
3. CMS will continue to monitor the Model, in accordance with Section 14, and evaluate the Model, in accordance with Section 16, throughout the Transition Period.
4. The State will continue to monitor the Model in accordance with Section 14 and Appendix D of the Agreement throughout the Transition Period.
5. The Agreement Term will conclude automatically at the conclusion of the Transition Period.

3. CMS Legal Authority.

- a. **General Authority to Test Model.** The Innovation Center is authorized under Section 1115A of the Act 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)(B) provides a non-exhaustive list of examples of models that the Secretary may select for testing, 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 the Agreement or with the terms and conditions of the Medicare payment waivers as set forth in this Agreement or in separately issued documentation. See Section 5.a for a discussion of Medicare payment waivers and Section 5.b for a discussion of Fraud and Abuse waivers.
- c. **Medicare Authority.** The Medicare portions of the Model shall 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 shall operate in a manner consistent with all applicable Medicaid laws, rules, and regulations, including but not limited to all requirements of Maryland’s existing Medicaid state plan and any Section 1115(a) demonstration waivers, as amended or modified from time to time. The State shall ensure that its Medicaid state plan and any Section 1115(a) demonstration waivers are updated to accommodate any and all changes in payment methodologies that the State implements pursuant to this Agreement.
- e. **Model Program Participation Agreements.** CMS and, as applicable, the State will enter into participation agreements with Model Program participants to implement each of the Model Programs (“**Model Program Participation Agreements**”). These Model Program Participation Agreements will set forth the applicable Model Program requirements, including but not limited to those related to CMS payment, participants’ reporting and record retention obligations, and care delivery transformation responsibilities.

4. State Legal Authority.

- a. The State represents and warrants that the MDH has the legal authority under Title 2 of the Health General Article of the Annotated Code of Maryland to promote and guide the development of physical and behavioral health care for the State. In carrying out these responsibilities, the MDH has the authority to apply

for, receive, and spend federal funds; to enter into contracts; and to oversee the administration and implementation of contracts and programs including, but not limited to, those programs planned or contemplated under the Model for primary care, alignment of the health care system in Maryland, and population health improvement.

- b. The State also represents and warrants that the HSCRC has the legal authority under Title 19 of the Health General Article of the Annotated Code of Maryland to require all Regulated Maryland Hospitals to charge rates in accordance with the rules and regulations of the HSCRC, and, under Title 15 of the Insurance Article and Title 15 of the Health General Article of the Annotated Code of Maryland, to require all Maryland Payers to reimburse Regulated Maryland Hospitals on the basis of rates established by the HSCRC. The State represents and warrants that the HSCRC has the legal authority under Title 19 of the Health General Article of the Annotated Code of Maryland to promote the greatest efficiency in Maryland hospitals and is authorized to promote and approve alternative methods of both rate determination and payment for the duration of this Agreement in order to achieve the greatest efficiency.
- c. The State further represents and warrants that it has the legal authority to enter into this Agreement and has bound by law or by contract its contractor(s), all Regulated Maryland Hospitals, and all Maryland Payers to comply with the applicable terms and conditions of this Agreement and to contribute to all submissions to CMS required of the State pursuant to this Agreement.

5. Medicare Waivers.

- a. **Payment Waivers.** Subject to the provisions of this Agreement and as specified in this Section, CMS will waive the requirements of the Act listed in Appendix G of this Agreement and in separately issued documentation, if any, solely for purposes of testing the Model. The State may request, and the Secretary may consider, additional Medicare payment waivers. CMS may grant any waivers requested by the State at CMS's sole discretion. Such waivers, 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 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 the

Maryland Total Cost of Care Model 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 (each, a “**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. To the extent that a provision under the national Medicare FFS program not listed in Appendix G or otherwise referred to in this Agreement provides for a particular treatment for Section 1814(b) hospitals or Medicare FFS hospitals, the State may request an alternative approach for Regulated Maryland Hospitals under the Model, and CMS may, at its sole discretion, permit the requested alternative approach.

6. Model Financial Targets.

- a. The State shall meet each of the Annual Savings Targets calculated in accordance with Section 6.c, each of the Compounded Savings Targets calculated in accordance with Section 6.d, and shall not exceed the TCOC Guardrail defined in Section 6.e nor the All-Payer Revenue Limit defined in Section 6.f (collectively the “**Model Financial Targets**”).
- b. **Annual Medicare Savings Methodology.** The State intends to achieve at least \$1 billion in cumulative Annual Medicare Savings between MY1 and MY5 (2019-2023). For purposes of assessing the State’s performance against the Model Financial Targets described in this Section 6, for each Model Year during the Performance Period of the Model, and until the Parties agree to a Compounded Savings Target pursuant to Section 6.d, CMS will calculate the annual Medicare TCOC savings per Maryland Medicare Beneficiary (“**Annual Medicare Savings**”) in accordance with the methodology set forth in this Section 6.b and Appendix C of this Agreement. For purposes of calculating the Annual Medicare Savings:
 - i. If the Annual Medicare Savings in MY1 or MY2 exceeds the Annual Savings Target, as defined in Section 6.c.i, for that Model Year, then CMS will add one half of the difference between the Annual Medicare Savings for that Model Year and the Annual Savings Target for that

Model Year to the Annual Medicare Savings for the subsequent Model Year.

- ii. CMS will include payments that do not otherwise appear on Part A or Part B claims (“**Non-Claims Based Payments**”) in the calculation of the Annual Medicare Savings. Non-Claims Based Payments include, but are not limited to, those payments made under a current or future demonstration, pilot, or other time limited program, including but not limited to the Maryland Primary Care Program and the Medicare Shared Savings Program, CMS bundled payment programs, and CPC+. CMS and the State will evaluate the need to incorporate other Non-Claims Based Payments to providers that may occur through future Medicare payment modifications or through material changes in cost report settlements. CMS will provide the State with data on any Non-Claims Based Payments that are included in the calculation of the Annual Medicare Savings.
- iii. If CMS and the State determine that the inclusion of shared savings payments made under the Medicare Shared Savings Program or another shared savings initiative in the calculation of both the Maryland Medicare TCOC per Beneficiary and National Medicare TCOC per Beneficiary would adversely affect the State’s ability to meet the Model Financial Targets described in this Section 6, CMS may adjust the trend factors or benchmarks used under one or more shared savings initiatives to help enable the State to meet the remaining Model Financial Targets required under the Model.
- iv. CMS will include Outcomes-Based Credits deemed approved in accordance with Section 7.b in the calculation of the Annual Medicare Savings.

c. **Annual Savings Targets.**

- i. The annual savings target for Maryland Medicare TCOC per Beneficiary (“**Annual Savings Target**”) for each Model Year from MY1 (2019) through MY5 (2023), shall be:

MY 1 (2019): \$120 million
MY 2 (2020): \$156 million
MY 3 (2021): \$222 million
MY 4 (2022): \$267 million
MY 5 (2023): \$300 million

- ii. Until CMS and the State agree upon a formulation for the Compounded Savings Target in accordance with Section 6.d., the Annual Savings Targets for each Model Year from MY6 through MY8 will be equal to the previous Model Year’s Annual Savings Target plus \$36 million.
 - iii. The State may submit to CMS a written request that CMS delay the timeline for meeting the Annual Savings Target for MY5 if delays by CMS in meeting one or more deadlines under this Agreement materially and adversely affect the State’s ability to meet one or more of the Annual Savings Targets for MY1 through MY4. CMS may, in CMS’s sole discretion, delay the timeline for meeting the Annual Savings Target for MY5.
- d. **Compounded Savings Targets.** In MY5, CMS and the State will agree upon a methodology for calculating an annual savings target for the compounded growth in Maryland Medicare TCOC per Beneficiary for MY6 through MY8 (“**Compounded Savings Target**”). The Compounded Savings Target calculated pursuant to this methodology must ensure that the growth rate in the Maryland Medicare TCOC per Beneficiary does not exceed the growth rate in the National Medicare TCOC per Beneficiary over a period of time agreed upon by CMS and the State.
 - i. CMS and the State will amend Section 6.b and Appendix C of this Agreement to reflect the agreed-upon Compounded Savings Target methodology and updated methodology for calculating Annual Medicare Savings. By no later than July 1 of each Model Year from MY5 through MY7, CMS will calculate the Compounded Savings Target for the following Model Year.
 - ii. For purposes of assessing the State’s performance against the Compounded Savings Target, CMS and the State will calculate a baseline for the growth in the Maryland Medicare TCOC per Beneficiary, which will be adjusted to account for:
 1. Any Exogenous Factors;
 2. Any difference between the Annual Medicare Savings and the Annual Savings Target for MY5; and
 3. Any Outcomes-Based Credits deemed approved by CMS in accordance with Section 7.b.
- e. **TCOC Guardrail.** During the Performance Period of the Model, the growth

rate in the Maryland Medicare TCOC per Beneficiary must not exceed the growth rate in the National Medicare TCOC per Beneficiary by more than 1 percent for any given Model Year and must not exceed the growth rate in the National Medicare TCOC per Beneficiary by any amount for two or more consecutive Model Years (“**TCOC Guardrail**”).

f. **All-Payer Revenue Limit.**

- i. By no later than May 1 of each Model Year during the Performance Period of the Model, beginning in MY2, the State will calculate the All-Payer Revenue Limit for the Model Year, as defined and calculated in accordance with Appendix B of this Agreement.
- ii. By no later than May 1 of each Model Year, beginning in MY2 through MY8, the State will compare the actual Regulated Gross Patient Service Revenue for the prior Model Year to the All-Payer Revenue Limit for that Model Year, each defined and calculated in accordance with the specifications in Appendix B of this Agreement.
- iii. The State shall provide the results of the calculations performed pursuant to this Section 6.f and Appendix B of this Agreement to CMS. To the extent permitted under applicable law, the State shall grant CMS access to all underlying data, including access to contractors involved in performing such calculations, and contract deliverables related to such calculations, including the Regulated Gross Patient Service Revenue, which the State shall report in a manner consistent with Section III of Appendix B of this Agreement.
- iv. The State may request to update the Growth Limit used to calculate the All-Payer Revenue Limit, as specified in Appendix B of this Agreement, subject to CMS review and approval. Such requests may be initiated by the State for reasons including, but not limited to, the following:
 1. Changes in Maryland law affecting the State’s authority to regulate Regulated Revenue;
 2. Changes in the in and out-migration of Maryland residents;
 3. Exogenous Factors; and
 4. Changes in service regulation or facility regulation that result in material increases or decreases in Regulated Revenue.

Any changes to the specifications for calculating the All-Payer Revenue Limit requested by the State will be made by CMS at CMS's sole discretion.

- g. **Exogenous Factors.** As needed, CMS may adjust the calculation of any Model Financial Target to take into account any Exogenous Factors. The State may submit to CMS a written request that CMS adjust a Model Financial Target. Any such adjustment will be made by CMS at CMS's sole discretion.
- 7. Outcomes-Based Credits.** The State shall be responsible for addressing a minimum of three population health priorities for Maryland residents in accordance with this Section 7.

 - a. At any time following the Effective Date of the Agreement, for a minimum of three population health priorities, the State must propose to CMS for approval methodologies for assessing the State's performance on each population health priority.

 - i. For each population health priority, the State must submit the following information:

 1. Specifications for appropriate population health measures and applicable performance targets;
 2. A methodology, based on validated research methodologies, to assess the State's performance on each measure and target relative to a comparison group or targeted level of improvement; and
 3. An estimate of the savings to Medicare that could be expected due to an improvement by the State on each measure and target.
 - ii. CMS will inform the State in writing of its decision to approve or reject the State's proposed measures, targets, and methodologies within 180 days of receipt.
 - b. On or before December 31 of each Model Year from MY1 through MY8, the State may submit to CMS a proposal for Outcomes-Based Credits to be applied to the Annual Medicare Savings for the Model Year in which the proposal is submitted.

 - i. The State's proposed Outcomes-Based Credits must correspond to one or more population health measures and performance targets approved by CMS in accordance with Section 7.a.ii.

- ii. The State's proposal must be submitted together with all data, programs, documentation, and other information requested by CMS, and must include at least the following for each population health measure approved by CMS in accordance with Section 7.a.ii:
 - 1. The State's performance against the applicable CMS-approved performance target; and
 - 2. An estimate of the savings to Medicare due to the State's performance compared with that performance target.
- iii. If CMS does not reject the State's proposal or request additional data, programs, documentation, or any other information from the State in writing within 120 days of the State's submission thereof, the proposal is deemed approved.

8. Hospital Payment Program.

a. Operations of Maryland's Rate-Setting System.

- i. **General.** The Parties acknowledge that this Model is predicated on Md. Code Ann. Health-Gen. §19-201 et seq., and the State's maintenance of an all-payer rate-setting system whereby:
 - 1. The total costs of all Regulated Maryland Hospitals' services are reasonable;
 - 2. The aggregate charge rates established by the HSCRC for each Regulated Maryland Hospital are related reasonably to the Regulated Maryland Hospital's aggregate costs;
 - 3. Rates are set equitably among all purchasers of hospital services, without undue discrimination or preference; and
 - 4. The HSCRC may review and approve or disapprove the reasonableness of any rate or amount of revenue that a Regulated Maryland Hospital sets or requests. The State shall require all Regulated Maryland Hospitals to submit claims to Medicare FFS using the charge rates established by the HSCRC pursuant to Md. Code Ann. Health-Gen. §19-201 et seq.
- ii. **Population-Based Payment.** Over the Performance Period of the Model, the State must use its all-payer rate-setting authority under Md. Code Ann. Health-Gen. §19-201 et seq. to ensure that 95 percent of all

Regulated Revenue for Maryland residents is paid according to a Population-Based Payment methodology and that such Population-Based Payments are subject to adjustments based on the hospital quality and value-based payment programs developed and administered by the State in accordance with Section 8.d.

1. For purposes of this Section 8.a.ii, the term Population-Based Payment is defined to mean hospital payment that either (1) is directly population-based, such as prospectively tying hospitals' reimbursement to the projected utilization of services by a specific population or subpopulation of Maryland residents, or (2) establishes a fixed budget for Regulated Maryland Hospitals for services projected to be furnished.
2. The Parties acknowledge that, prior to the Effective Date, the State submitted and CMS approved a proposal identifying the State's Population-Based Payment methodology and which Regulated Revenue is paid under the CMS-approved Population-Based Payment methodology, to be in effect until the State wishes to modify it in accordance with Section 8.a.iii.
3. By no later than May 1 of each Model Year, beginning in MY2, the State must report to CMS the percentage of all Regulated Revenue for Maryland residents paid under a Population-Based Payment methodology during the previous Model Year. This percentage must be calculated by dividing the aggregate amount of Regulated Revenue for Maryland residents paid according to a CMS-approved Population-Based Payment methodology during the previous Model Year by the aggregate amount of all Regulated Revenue for Maryland residents during the previous Model Year.

iii. Design and Approval of New Payment Methods.

1. If the State wishes to adopt a new payment methodology for Regulated Maryland Hospitals, including but not limited to a new Population-Based payment, or to modify which Regulated Revenue is paid under the CMS-approved Population-Based Payment methodology described in Section 8.a.ii, the State shall provide advanced written notice to CMS regarding the proposed new payment methodology.

2. Upon notification, if after consultation with the State, CMS believes the change to be substantive, CMS may request, within seven business days of receipt of the State's notification, a detailed proposal and operational plan describing the new payment methodology for review and approval by CMS. CMS will make reasonable efforts to approve or reject the State's proposals within 180 days of receipt.
3. Payment methodologies employed by the State on the Effective Date, including the rate-setting system described in Section 8.a.i, shall not require prior CMS approval pursuant to this Section 8.a.iii.
4. Under no circumstances will CMS approve a proposal under which less than 95 percent of all Regulated Revenue for Maryland residents is paid according to a Population-Based Payment methodology.

b. Medicare Payments for Hospital Services.

- i. **General.** CMS will pay each Regulated Maryland Hospital through the applicable Medicare Administrative Contractor(s) (“MAC”) on the basis of the charge rate included on the Medicare FFS claims submitted by the Regulated Maryland Hospital to the MAC, less the Public Payer Differential calculated by the State in accordance with Section 8.b.ii, and subject to the MPA adjustment described in Section 8.c.iii.2. The Public Payer Differential will be applied prior to subtracting any applicable deductible or coinsurance amount, and prior to any applicable Medicare secondary payment adjustments.
- ii. **Public Payer Differential.** Prior to the start of MY1 (January 1, 2019), the State shall provide a percentage difference between the rate established by the HSCRC for a Regulated Maryland Hospital for a given charge and the lesser rate to be paid by public payers (Medicare, Medicaid, and CHIP) to a Regulated Maryland Hospital for the same charge (“**Public Payer Differential**”). This Public Payer Differential will remain in effect unless and until CMS approves a change in the Public Payer Differential proposed by the State in accordance with this Section 8.b.ii.
 1. Beginning in MY1 for implementation in MY2, the State may

submit to CMS a request to change the Public Payer Differential calculated by the State under any of the following circumstances:

- a. To enable the State to meet the Annual Savings Target for the subsequent Model Year, provided that hospital expenditures for the current Model Year are less than the All-Payer Revenue Limit calculated by the State in accordance with Section 6.f and Appendix B of this Agreement for that Model Year.
 - b. To effectuate changes in hospital overhead allocations or other factors used in Maryland's rate-setting system described in Section 8.a that may be necessary to adjust, recalibrate, or modernize Maryland's rate-setting structure while avoiding shifting costs.
2. The State shall submit a request to change the Public Payer Differential no fewer than 120 days before the first day of the Model Year in which the modified Public Payer Differential would take effect, or by such other deadline specified by CMS.
 3. CMS will make reasonable efforts to approve or reject the State's request in writing within 60 days of receipt.
- c. **Medicare Performance Adjustment ("MPA").** After each Model Year during the Performance Period of the Model, the State shall calculate an MPA for each Regulated Maryland Hospital in accordance with Section 8.c.iii.1, which CMS will apply to Medicare FFS payments made during the subsequent Rate Year pursuant to Section 8.c.iii.2.
- i. **MPA Proposal.** For each Model Year during the Performance Period of the Model, in a form and manner and by a date specified by CMS, the State shall submit to CMS a proposed MPA calculation methodology, subject to CMS review and approval pursuant to Section 8.c.ii ("**MPA Proposal**"). The State's MPA Proposal must include the following components:
 1. A proposed algorithm for attributing Medicare FFS Beneficiaries to Regulated Maryland Hospitals for the purpose of calculating the MPA for each Regulated Maryland Hospital ("**Medicare Beneficiary Attribution Algorithm**"). The State's proposed Medicare Beneficiary Attribution Algorithm must specify which

Medicare FFS Beneficiaries will be included in the MPA and be based on one or more methodologies deemed appropriate by CMS (e.g., a Medicare FFS Beneficiary’s residency, the relationship—formal or based on referral patterns—between a Medicare FFS Beneficiary’s primary care provider and a Regulated Maryland Hospital, or the Regulated Maryland Hospital where the Medicare FFS Beneficiary receives the plurality of hospital services), and must result in the attribution to one or more Regulated Maryland Hospitals of at least 95 percent of Maryland Medicare Beneficiaries who are enrolled in both Part A and Part B for purposes of inclusion in the MPA calculation for those Regulated Maryland Hospitals.

2. The categories of Medicare FFS costs, excluding certain categories proposed for exclusion by the State, to be attributed to each Regulated Maryland Hospital (“**Attributed Medicare Costs**”) for purposes of calculating the total cost of care in the baseline period (“**TCOC Baseline**”) and the total cost of care during the Model Year (“**TCOC Performance**”) for each Regulated Maryland Hospital.
3. A proposed methodology to calculate the TCOC Baseline for each Regulated Maryland Hospital, based on the Attributed Medicare Costs for the Medicare FFS Beneficiaries attributed to the Regulated Maryland Hospital for the baseline period using the Medicare Beneficiary Attribution Algorithm proposed by the State in accordance with Section 8.c.i.1.
4. A proposed methodology to calculate a benchmark TCOC (“**TCOC Benchmark**”) for each Regulated Maryland Hospital. The State’s proposed TCOC Benchmark methodology must include a proposed trend factor—to be applied to the TCOC Baseline calculated for each Regulated Maryland Hospital in order to calculate the TCOC Benchmark.
5. A proposed methodology to calculate the TCOC Performance for each Regulated Maryland Hospital based on the Attributed Medicare Costs for the Medicare FFS Beneficiaries attributed to the Regulated Maryland Hospital for the relevant Model Year using the Medicare Beneficiary Attribution Algorithm proposed by the State in accordance with Section 8.c.i.1.

6. A proposed methodology to be used in Step 5 of the calculation described in Section 8.c.iii.1 to make adjustments to the results of Step 4 of such calculation based on efficiency or other measures.
 7. A proposed methodology to calculate an MPA-specific quality score for each Regulated Maryland Hospital (“**Quality Adjustment Score**”). The State’s proposed Quality Adjustment Score methodology must utilize a subset of the quality measures included in Appendix D of this Agreement, at least one of which must satisfy the requirements of 42 CFR § 414.1415(b)(2), and at least one of which must satisfy the requirements of § 414.1415(b)(3). To meet these requirements, the State’s proposed Quality Adjustment Score methodology must include the following two measures in its proposed Quality Adjustment Score methodology:
 - a. The all-payer case-mix adjusted readmission rate for patients who were hospitalized at an acute care hospital and experienced an unplanned readmission to an acute care hospital.
 - b. The composite result for Maryland’s Hospital Acquired Condition program.
 8. A proposal for the maximum share of Medicare FFS payments made to each Regulated Maryland Hospital that can be lost or gained as a result of the application of the MPA (“**Maximum Revenue at Risk**”). For MY1, the State’s proposal for the Maximum Revenue at Risk must be at least 1.0 percent.
 9. Beginning in MY2, a proposal for the threshold percentage between the Attributed Medicare Costs for a Regulated Maryland Hospital and TCOC Benchmark for that Regulated Maryland Hospital at which the Maximum Revenue at Risk is triggered for that Regulated Maryland Hospital (“**Maximum Performance Threshold**”). For MY1, the Maximum Performance Threshold is 3 percent.
- ii. **CMS Review.** Within thirty (30) days of receipt, CMS will either approve or request revisions to the State’s MPA Proposal. If CMS requests revisions to one or more components of the State’s MPA Proposal, the State shall submit such revisions to CMS within thirty (30)

days of CMS's request. If CMS does not request further revisions within thirty (30) days of receiving such revisions from the State, those revisions will be deemed to be approved.

iii. **Calculation and Application of the MPA.** By May 31 of each Model Year, beginning in MY2, the State shall calculate the MPA for each Regulated Maryland Hospital for the prior Model Year in accordance with the CMS-approved MPA Proposal and shall inform CMS of each such calculated MPA. The State shall also provide any data or supporting documentation as requested by CMS to validate the State's calculation of the MPA.

1. The State shall calculate the MPA for each Regulated Maryland Hospital according to the following steps:

Step 1: Calculate a TCOC Benchmark for the Regulated Maryland Hospital in accordance with the CMS-approved TCOC Benchmark methodology, including the application of the CMS-approved trend factor.

Step 2: Calculate the Regulated Maryland Hospital's TCOC Performance during the Model Year using the CMS-approved TCOC Performance methodology.

Step 3: Calculate the Quality Adjustment Score for the Regulated Maryland Hospital using the CMS-approved Quality Adjustment Score methodology.

Step 4: Calculate the product of "A" and "B" (defined below), unless the difference between the Regulated Maryland Hospital's TCOC Performance and its TCOC Benchmark is more than the Maximum Performance Threshold, in which case, the result of this Step 4 for the Regulated Maryland Hospital is equal to the Maximum Revenue at Risk.

1. "A" is the $[\text{TCOC Benchmark} - \text{TCOC Performance}] / \text{TCOC Benchmark} * [\text{Maximum Revenue at Risk} / \text{Maximum Performance Threshold}]$, and
2. "B" is $(1 + \text{Quality Adjustment Score})$ when "A" is greater than or equal to zero, and is $(1 - \text{Quality Adjustment Score})$ when "A" is less than zero.

Step 5: Calculate the MPA for the Regulated Maryland Hospital by applying adjustments for efficiency or other measures to the result of Step 4 according to the CMS-approved methodology. The MPA may exceed the Maximum Revenue at Risk.

2. **Application of the MPA.** During the Rate Year that begins immediately following the Model Year for which the MPA is calculated by the State in accordance with Section 8.c.iii.1, CMS will adjust each Medicare FFS payment to a Regulated Maryland Hospital by that Regulated Maryland Hospital's MPA.

- d. **Maryland Hospital Quality and Value-Based Programs.** During the Performance Period of the Model, the State will develop and administer hospital quality and value-based payment programs in accordance with this Section 8.d. The State will use the results of the State's hospital quality and value-based payment programs to adjust Population-Based Payments for Regulated Maryland Hospitals on an all-payer basis in accordance with Section 8.a.ii.

- i. **Quality and Value-Based Program Performance Targets.** For each Model Year, the State will set performance targets and select quality measures for the State's hospital quality and value-based payment programs in accordance with the following:

1. The State shall select annual performance targets that meet or exceed the results achieved under the Maryland All-Payer Model. The State may change the performance targets in consultation with CMS.
2. The State shall utilize similar categories of quality measures to those used for the programs established under Section 1886(o) (Hospital Value Based Purchasing program), Section 1886(p) (Hospital Acquired Condition Reduction program), and Section 1886(q) (Hospital Readmissions Reduction program) of the Act, subject to the following exceptions:
 - a. CMS recognizes that the State may utilize efficiency, performance, and outcome measures not utilized in the programs listed in Section 8.d.i.2, but that tie to the Model's goals of alignment across the delivery system and reductions in unnecessary and potentially avoidable utilization.

- b. The State shall develop and utilize population health measures as part of its portfolio of hospital quality and value-based payment measures.
3. The State's hospital quality and value-based payment programs described in this Section 8.d must achieve or surpass the measured results in terms of patient outcomes and cost savings as those programs established under Sections 1886(o), 1886(p), and 1886(q) of the Act.

ii. **Reports.**

1. **State Reporting.** The State shall submit to CMS, in a form and manner and by a date specified by CMS:
 - a. The State's performance targets and quality measures for the State's hospital quality and value-based payment programs, together with the basis for the benchmark used in setting each such target, and the comparison (national or peer) performance on each such target (if available).
 - b. An annual report documenting any changes in the State's hospital quality and value-based payment programs as compared to the prior Model Year, the all-payer performance against the State's measures and targets during the Model Year, the linkage between the measures and targets and the Population-Based Payments defined in Section 8.a.ii, and any savings achieved as a result of the State's hospital quality and value-based payment programs during the Model Year. The annual report must also demonstrate that the State's hospital quality and value-based payment programs continue to achieve or surpass the measured results in terms of patient outcomes and cost savings of those programs established under Sections 1886(o), 1886(p), and 1886(q) of the Act. Each such annual report will be considered by CMS in the Model monitoring described in Section 14 and the Model evaluation described in Section 16.
 - c. A report identifying ways, to the extent consistent with State law, to lower barriers to entry and reduce regulatory burden or other obstacles in order to promote access to care and competition in the healthcare market.

2. **CMS Reporting.**

- a. By no later than May 1 of each Model Year, beginning in MY2, CMS will calculate and provide the State's health oversight agencies, the HSCRC and MDH respectively, with the readmissions rates for the previous Model Year. Such rates will be provided for each Regulated Maryland Hospital as well as for hospitals nationally. These calculations will be based on data for the prior Model Year.
 - b. By no later than June 1 of each Model Year, beginning in MY2, CMS will provide to the State performance measures for Regulated Maryland Hospitals as if they were included in CMS's Hospital Value-Based Purchasing program and Hospital Acquired Conditions Reduction program for the prior Model Year.
- iii. **CMS Quality Program Waiver Determination.** CMS will assess whether the State has demonstrated in the report submitted to CMS pursuant to Section 8.d.ii.1.a that the State is implementing hospital quality and value-based payment programs that achieve or surpass the measured results in terms of patient outcomes and cost savings to those programs established under Sections 1886(o), 1886(p) and 1886(q) of the Act.
- iv. **Hospital Inpatient Quality Reporting (IQR), Outpatient Quality Reporting (OQR), and Readmissions Reduction Reporting.** The State will work with CMS to ensure that the data submitted by Regulated Maryland Hospitals under the Hospital Inpatient Quality Reporting (IQR) Program and Hospital Outpatient Quality Reporting (OQR) Programs, as described in this Section 8.d.iv, is included in national Medicare measures and published by CMS in an accurate and appropriate manner. CMS will include data for Maryland hospitals in the Clinical Data Abstraction Center for auditing purposes.
1. Regulated Maryland Hospitals will continue to be subject to the reporting requirements under Section 1886(b)(3)(B)(viii)(II) through (XI) of the Act and implementing regulations at 42 CFR § 412.140 (Hospital IQR Program), which includes the authority to publish such reported information (e.g., on the Hospital Compare website and for the Overall Hospital Quality Star Rating).

2. Regulated Maryland Hospitals will continue to be subject to the reporting requirements under Section 1833(t)(17)(B) through (E) of the Act and implementing regulations at 42 CFR § 419.46 (Hospital OQR Program), which includes the authority to publish such reported information (e.g., on the Hospital Compare website and for the Overall Hospital Quality Star Rating).
 3. Regulated Maryland Hospitals will continue to be subject to the reporting requirements under Section 1886(q)(6) and implementing regulations at 42 CFR § 412.154 (Readmissions Reductions Program Reporting), and CMS will continue to have the authority to publish such reported information (e.g., on the Hospital Compare website and for the Overall Hospital Quality Star Rating).
- v. **Regulated Revenue at Risk.** The State must ensure that the aggregate percentage of Regulated Revenue at risk under the State’s hospital quality and value-based payment programs administered by the State in accordance with this Section 8.d, together with the MPA applied in accordance with Section 8.c.iii.2 is equal to or greater than the aggregate percentage of revenue at risk under the programs established under Sections 1886(o), 1886(p), and 1886(q) of the Act (“**Revenue at Risk Standard**”). For purposes of assessing the State’s compliance with this requirement, for each Model Year:
1. CMS will provide the State with the aggregate percentage of revenue at risk under the programs established under Sections 1886(o), 1886(p), and 1886(q) of the Act.
 2. The State shall report to CMS the aggregate percentage of Regulated Revenue at risk under both the State’s hospital quality and value-based purchasing programs and the MPA. To the extent permitted by applicable law, the State shall make available, at CMS’s request, all underlying data, including access to contractors, contract deliverables, and software systems used to perform the calculation, as necessary to validate the State’s calculation pursuant to this Section 8.d.v.2. The information reported to CMS by the State pursuant to this Section 8.d.v.2 will be further considered by CMS in the Model monitoring described in Section 14 and the Model evaluation described in Section 16.

3. CMS will compare the percentages of revenue at risk described in Section 8.d.v.1 and Section 8.d.v.2 to determine whether the State has satisfied the Revenue at Risk Standard. If CMS determines that the State has failed to satisfy the Revenue at Risk Standard, it will be an Other Event as defined in Section 12.d.i.

9. Care Redesign Program.

- a. The State and CMS shall administer the CRP in accordance with the terms of Section 9 of this Agreement and the CRP Participation Agreement.

b. CRP Track Proposals and Amendments.

- i. By the deadlines specified in the CRP Calendar, the HSCRC shall submit to CMS a Track Implementation Template for each new CRP Track that the HSCRC wishes to implement. The HSCRC shall promptly submit to CMS any additional information that CMS determines is necessary to complete its review of the proposed Track Implementation Template, including amendments to the HSCRC's CRP Monitoring Plan.
- ii. If the HSCRC wishes to modify a CRP Track after it has been implemented, the HSCRC shall submit to CMS an amended Track Implementation Template no fewer than 120 days before the first day of the Model Year in which the CRP Track modifications would be implemented or by such other deadline specified by CMS. The HSCRC shall promptly submit to CMS any additional information that CMS determines is necessary to complete its review of the amended Track Implementation Template, including amendments to the HSCRC's CRP Monitoring Plan. CRP Track modifications must become effective on the first day of the relevant Model Year.
- iii. A Track Implementation Template must include at least the following information, as applicable:
 1. A list of available CRP Interventions;
 2. The methodology that will be used by the HSCRC to calculate PAU Savings;
 3. The methodology that must be used by the CRP Hospital to calculate Incentive Payments;
 4. Care Partner Qualifications, if applicable;

5. Instructions requiring each CRP Hospital to—
 - a. Determine the amount and nature of Intervention Resources provided to a Care Partner in a manner substantially based on criteria related to quality of care and the performance of Allowable CRP Interventions, consistent with the CRP Participation Agreement.
 - b. Specify the Intervention Resources it proposes to distribute to Care Partners during the upcoming CRP Performance Period;
 - c. Identify the cost of each Intervention Resource based on the CRP Hospital’s actual costs for the Intervention Resource or a reasonable estimate of such costs, provided that such actual or estimated costs are consistent with general market value; and
 - d. Select Care Partners in accordance with written care partner selection criteria that satisfy the CRP Participation Agreement and to identify such criteria in completing the Track Implementation Protocol.
6. Any new waivers requested; and
7. An operational plan, if needed, for any payment modifications.
- iv. CMS will make its best efforts to approve or reject in writing each proposed or amended Track Implementation Template within 60 days of receipt, if no new waivers are required. If a Track Implementation Template requires new waivers, HHS will make reasonable efforts to approve or reject the track within 180 days, consistent with the process outlined in Section 12.
- v. If CMS approves a proposed or amended Track Implementation Template, the HSCRC shall notify Regulated Maryland Hospitals that they may choose to implement the CRP Track in the applicable Model Year.
- vi. A Track Implementation Template that has been approved by CMS constitutes a “Track Implementation Protocol.”
- vii. The HSCRC shall make Track Implementation Protocols available to Regulated Maryland Hospitals that are interested in participating in the CRP.

- viii. The HSCRC shall not permit any hospital to implement a CRP Track unless the hospital is a Regulated Maryland Hospital that is a party to a CRP Participation Agreement that is in effect.
 - ix. CMS shall maintain a calendar setting forth the deadlines for various activities to be conducted by parties in implementing the CRP (“**CRP Calendar**”). CMS may modify the CRP Calendar without the consent of the State.
- c. **CRP Tracks and Alignment with Maryland Payers.** A CRP Track may involve alignment with private payers.
- i. The State shall not use Medicare or Medicaid physician payment data as the basis for the design of any new or amended CRP Track for private payers or to determine the allocation of incentive payments to physicians in a CRP Track that includes treatments furnished to non-Medicare or non-Medicaid beneficiaries.
 - ii. The State shall reference independent databases, when applicable, in working with private payers and other stakeholders in the design of CRP Tracks that involve alignment with private payers.
 - iii. The State shall not set Medicare physician fee schedule rates, and the parties acknowledge that the State will not set physician payment rates for private payers under the CRP or otherwise.
- d. **PAU Savings Methodology**
- i. The HSCRC shall determine PAU Savings for a CRP Performance Period in accordance with a methodology that satisfies the following criteria:
 - 1. The methodology measures Medicare cost savings achieved by the CRP Hospital through the reduction of PAU and other savings that the CRP Hospital achieved as a result of the reduced PAU;
 - 2. The methodology includes widely accepted PAU measures, such as PAU measures that are recognized by the Agency for Healthcare Research and Quality or the National Committee for Quality Assurance; and
 - 3. The methodology does not permit duplicate accounting of PAU Savings.

- ii. The HSCRC shall calculate PAU Savings for each CRP Hospital using the PAU Savings methodology contained in the Approved Track Implementation Protocol for the relevant CRP Track.
- iii. The HSCRC shall notify each CRP Hospital of its PAU Savings for the relevant CRP Track and CRP Performance Period, as required under the CRP Participation Agreement.

e. **Incentive Payment Methodology**

- i. The HSCRC shall specify in its Track Implementation Template a methodology for calculating Incentive Payments and Downstream Incentive Payments (“**Incentive Payment Methodology**”) that satisfies the following criteria:
 - 1. The methodology is substantially based on criteria related to quality of care and the performance of CRP Interventions and may take into account the amount of CRP Interventions performed by a Care Partner relative to other Care Partners;
 - 2. The methodology is applied separately for each individual or entity that qualifies for an Incentive Payment or Downstream Incentive Payment and does not result in an Incentive Payment or Downstream Incentive Payment that represents an average or weighted payment for CRP Interventions performed by multiple Care Partners or Downstream Care Partners; and
 - 3. The methodology is not based on the volume or value of referrals of federal health care program business furnished to patients who are not Maryland Medicare Beneficiaries.
- ii. The HSCRC shall ensure that each CRP Hospital uses the Incentive Payment Methodology set forth in the relevant Approved Track Implementation Protocol to calculate each Incentive Payment and Downstream Incentive Payment distributed to a Care Partner and Downstream Care Partner, respectively.

f. **Intervention Resource Allocation**

- i. The HSCRC shall require each CRP Hospital to specify in its Track Implementation Protocol the Intervention Resources it proposes to distribute to Care Partners and the cost of those Intervention Resources.

- ii. If the HSCRC determines an Intervention Resource Allocation for a CRP Hospital, it shall make such determination based on the following:
 - 1. The CRP Hospital's actual costs for each Intervention Resource, if known, or a reasonable estimate of such costs; and
 - 2. The portion of the CRP Hospital's Intervention Resource Allocation for the previous CRP Performance Period, if any, that was actually spent.
- iii. The HSCRC may deny funding, in whole or in part, for one or more Intervention Resources specified in the Track Implementation Protocol completed by a CRP Hospital.
- iv. The HSCRC shall include each CRP Hospital's Intervention Resource Allocation, if any, for the relevant CRP Track and CRP Performance Period in the CRP Hospital's relevant Approved Track Implementation Protocol.

g. Incentive Payment Pool.

- i. The HSCRC shall determine each CRP Hospital's Incentive Payment Pool for a CRP Performance Period by calculating the amount by which PAU Savings achieved by the CRP Hospital for the relevant CRP Track exceeds the Intervention Resource Allocation, if any, for that CRP Track and multiplying that amount by 1 + the Quality Adjustment Score. The Quality Adjustment Score shall be calculated in accordance with Section 8.c.i.6 of this Agreement.
- ii. The HSCRC shall calculate PAU Savings using the PAU Savings methodology contained in the CMS approved Track Implementation Template for the relevant CRP Track, which must also be set forth in the CRP Hospital's Approved Track Implementation Protocol.
- iii. The HSCRC shall notify each CRP Hospital of its Incentive Payment Pool, if any, for the relevant CRP Track and CRP Performance Period as required under the CRP Participation Agreement.
- iv. If the HSCRC learns that an Incentive Payment Pool determination was calculated incorrectly, it shall notify CMS promptly.

h. Monitoring the CRP

- i. By the deadlines specified in the CRP Calendar, the HSCRC shall develop and submit to CMS a CRP Monitoring Plan, which shall include provisions regarding review of CRP Reports to determine CRP Hospital compliance with relevant Approved Track Implementation Protocols and periodic reporting to CMS regarding its monitoring activities.
- ii. The CRP Monitoring Plan shall specify that the HSCRC shall ensure that each CRP Hospital has, upon submission of a CRP Report, certified the following:
 1. That the CRP Report is true, accurate, and complete; and
 2. That if the CRP Hospital learns that a submitted CRP Report is not true, accurate, or complete, it will promptly submit a revised CRP Report.
- iii. If the HSCRC amends its CRP Monitoring Plan or otherwise modifies its CRP Monitoring Plan, it shall submit the revised CRP Monitoring Plan to CMS for review.
- iv. CMS shall review the CRP Monitoring Plan within 30 days of receipt and shall either approve the plan or request revisions. If CMS requests revisions to the plan, the HSCRC shall submit a revised plan to CMS within 30 days. CMS shall review the revisions within 30 days of receipt and either approve or reject it. The HSCRC shall not implement a CRP Monitoring Plan, including a revised CRP Monitoring Plan that has not been approved by CMS. The HSCRC shall monitor the CRP in accordance with the CRP Monitoring Plan most recently approved by CMS.
- v. The HSCRC shall submit to CMS a report on the HSCRC's monitoring activities and its implementation of its CRP Monitoring Plan ("**CRP Monitoring Report**") by the deadlines specified in the CRP Calendar.
- vi. In addition to the requirements of this section, the HSCRC and CMS shall continue to monitor the Model in accordance with Section 14 of this Agreement.
- vii. The HSCRC shall promptly notify CMS in writing if it has failed to comply with any of the terms of this Section 9, or if it becomes aware as a result of its monitoring activities or through other means, that a CRP Hospital failed to comply with any of the terms of the CRP Participation Agreement. Such notice shall specify the noncompliance, the relevant

facts, and in the case of a CRP Hospital's noncompliance, whether it recommends that any remedial action should be imposed, and the type of remedial action that should be imposed, if any.

- viii. The State shall not opine on or offer guidance regarding whether any arrangement complies with the terms of any Fraud and Abuse Waiver.

10. Maryland Primary Care Program.

- a. **Maryland Primary Care Program (“MDPCP”).** CMS will implement the MDPCP from MY1 through MY8, unless the duration of the MDPCP is modified pursuant to Section 10.f. CMS will accept applications from primary care practices and Care Transformation Organizations (“CTOs”) for participation in the MDPCP on an annual basis through MY5 (2023). Practices and CTOs that are eligible to participate in the MDPCP must sign an MDPCP Participation Agreement with CMS in order to participate in the MDPCP.
- b. **Care Management Fees (“CMFs”).** CMS will pay primary care practices and CTOs participating in the MDPCP a risk-stratified per-beneficiary per-month CMF based on the number of attributed Medicare FFS Beneficiaries.
- c. **Other Primary Care Payments.** CMS will pay primary care practices and CTOs participating in the MDPCP an at-risk Performance Based Incentive Payment (“PBIP”) on a per-beneficiary per-month basis, which must be repaid to CMS by MDPCP participants that fail to meet the applicable utilization and quality targets. CMS will also pay primary care practices participating in Track 2 of the MDPCP a comprehensive primary care payment (“CPCP”) calculated in accordance with the terms of the MDPCP Participation Agreement for practices.
- d. **State MDPCP Annual Report.** The State may submit to CMS an annual report on the MDPCP within 180 days of the last day of each Model Year, or by such other deadline specified by CMS (“MDPCP Annual Report”). The State's MDPCP Annual Report may include the following:
 - i. Suggested ways in which CMS can improve operations under the MDPCP, such as modifications to participating practices' care transformation requirements.
 - ii. Suggested utilization and quality measures for purposes of the PBIP that align with those used for purposes of the hospital quality and value-based payment program under the Hospital Payment Program (Section 8.d), the CRP (Section 9), and the Outcomes-Based Credits (Section 7).

- iii. Recommendations to CMS on components of the MDPCP implementation that are appropriate for delegation to the State.
- e. **Beneficiary Attribution.** Under the MDPCP, CMS will attribute Medicare FFS Beneficiaries to MDPCP-participating primary care practices for purposes of determining payments under the MDPCP, including the CMF. CMS will not attribute Medicare FFS Beneficiaries who are also eligible for Medicaid and are enrolled in the Maryland Medicaid Chronic Health Home program (under Section 1945 of the Act) to participating primary care practices unless the MDPCP is modified pursuant to Section 10.f to allow for the attribution of such beneficiaries.
- f. **Modifications.** The State may request modifications to the MDPCP, including but not limited to participation requirements, payment methodology and amounts, and the number of practices. CMS will modify its implementation to the extent practicable to accommodate the State’s request. If other payers voluntarily participate in the MDPCP, the State will not use Medicare or Medicaid payments to calculate payments or incentives made by private payers.

11. Proposals for Model Programs.

- a. **Optional Model Program Proposals.** During the Performance Period of the Model, the State may submit to CMS a proposal for a new Model Program or for modifications to an existing Model Program (i.e., the Hospital Payment Program, CRP, and the MDPCP) (“**Model Program Proposal**”). The State’s Model Program Proposal must include all of the information specified in Section 11.b.i and must be developed in accordance with Section 11.b.ii and Section 11.b.iii. The components of the State’s Model Program Proposal may include, but are not limited to, those specified in Section 11.b.iv. CMS will make reasonable efforts to approve or reject the State’s Model Program Proposal within 180 days of receipt. For modifications to one or more CRP Tracks in the CRP, the State shall meet the requirements set forth in Section 9.b.
- b. **Model Program Proposal Design.**
 - i. **Required Information.** The State’s Model Program Proposal must include the following information:
 - 1. How the proposed new Model Program or requested modification to an existing Model Program will enhance Maryland’s ability to meet the population health outcomes and measures and targets (see Section 7) and the Model Financial Targets (Section 6) established under this Agreement;

2. The potential impact of the proposed Model Program or modification to an existing Model Program on the growth rate in the Maryland Medicare TCOC per Beneficiary;
 3. Descriptions of any waivers authorized under Section 1115A(d)(1) of the Act that may be necessary to implement the proposed new Model Program or modification to an existing Model Program as part of the Model test;
 4. The perspective of key stakeholders that may be included in the new Model Program or modification to an existing Model Program;
 5. The State's plans, as applicable, to encourage participation in the new Model Program or modifications to existing Model programs; and
 6. The State's monitoring strategy and evaluation strategy for the new Model Program or modifications to an existing Model Program.
- ii. **Collaboration.** In developing the Model Program Proposal, the State shall collaborate with Care Partners and other stakeholders, including but not limited to physicians, hospitals, long-term care providers, post-acute care providers, behavioral health providers, and Maryland Payers, as appropriate, to ensure input into the new or modified Model Program. When developing the Model Program Proposal, the State shall seek to collaborate with providers and suppliers in all specialties.
- iii. **Alignment with Maryland Payers.** The State's Model Program Proposal may involve voluntary participation by and alignment with private payers. The State shall not set physician fee schedules for private payers or Medicare. Medicare and Medicaid physician payment data shall not be the basis for the design of any new Model program for private payers or for allocation of shared savings to physicians in a new Model Program that would affect payments for services furnished to only non-Medicare or non-Medicaid beneficiaries. The State shall reference independent databases, when applicable, in working with private payers and other stakeholders in the design of Model Programs that involve alignment with private payers.
- iv. **Examples of Proposed Model Program Components.** The State's Model Program Proposal may include one or more of the following components:

1. **Payment for Alcohol and Substance Use Disorder.** The State may submit to CMS a proposal to include payments for Medicare beneficiaries' alcohol, substance use disorder and wrap-around recovery services in a new or existing Model Program. CMS will only approve such proposal if it determines that it has the legal authority to do so. If CMS approves the State's proposal and a Model Program Participation Agreement is necessary to implement this new or modified Model Program, such Model Program Participation Agreement may include conditions of payment by Medicare for each participating Medicare-enrolled provider or supplier for the alcohol, substance use disorder and wrap-around recovery services, the methodology for determining the amount of such payments, and the reporting and operational requirements for participants. Such payments, if any, will be considered as investments for purposes of applying any Outcomes-Based Credits deemed approved in accordance with Section 7.b, except as otherwise agreed to in writing by CMS and the State.
 2. **Non-Hospital Performance Adjustment.** The State may submit to CMS a proposal to apply a performance adjustment to payments made to voluntarily participating non-hospital providers or suppliers, which may incorporate population health targets.
 3. **Alignment with Medicaid.** The State may submit to CMS a proposal to align Medicaid payment and delivery systems with the payment and delivery systems for Maryland Medicare Beneficiaries with the goal of limiting the growth rate in Medicaid TCOC for Maryland Medicaid beneficiaries, building on ongoing efforts for Medicaid beneficiaries who are, and who are not, enrolled in Medicaid managed care, particularly those who are dually eligible for Medicare and Medicaid.
- c. **Post-Acute and LTSS Proposal.** The State shall submit to CMS a proposal for a payment and delivery system transformation that includes post-acute care and long-term services and supports ("**Post-Acute and LTSS Proposal**") by no later than January 1, 2021. The Post-Acute and LTSS Proposal must include a plan for progressively increasing the State's accountability for Maryland Medicaid beneficiaries' TCOC in addition to the required information specified in Section 11.b.i. CMS shall review the Post-Acute and LTSS Proposal and decide whether to approve or reject the Post-Acute and LTSS Proposal.

12. Termination and Corrective Action Plan Triggers.

- a. **Review Factors considered by CMS.** CMS shall determine, in its sole discretion, whether a Triggering Event or Other Event, as defined in Section 12.c.i and Section 12.d.i, respectively, has occurred, as well as whether such Triggering Event or Other Event will require the submission of a corrective action plan (“CAP”) by the State pursuant to Section 12.b or other corrective action pursuant to Section 12.c.ii or 12.d.ii. In making these determinations, CMS will take into account the totality of the circumstances (e.g., whether the State can demonstrate that an Exogenous Factor caused the Triggering Event or Other Event, in whole or in part; whether a Model Financial Target was not met due to reliance on federal Medicare per capita cost growth estimates; whether a delay in a CMS deliverable required of CMS under this Agreement contributed to the Triggering Event or Other Event; or whether an adjustment is necessary to ensure that the Annual Savings Target for MY5 is met).
- b. **Warning Notice and Corrective Action Plan (“CAP”).**
 - i. If CMS determines that a Triggering Event (as defined in Section 12.c.i) or Other Event (as defined in Section 12.d.i) has occurred, CMS will provide written notice to the State (“**Warning Notice**”) that the State is not meeting a requirement of this Agreement, with an explanation and, as applicable, data supporting this determination.
 - ii. Within 45 days of receipt of the Warning Notice, the State shall submit a written response to CMS. CMS will review the State’s response within 45 days of receipt and will accept the response as sufficient or provide written notice requiring the State to submit a CAP (“**CAP Notice**”). The State will not be required to submit a CAP if the Triggering Event or Other Event was caused solely by reliance on federal Medicare per capita cost growth estimates and CMS determines that the State can make corrective action through the Hospital Payment Program for the following Model Year in accordance with the terms of this Agreement, through Maryland’s rate-setting system described in Section 8.a, the MPA described in Section 8.c, or other adjustments authorized under this Agreement.
 - iii. The State shall submit a proposed CAP to CMS within 30 days of receipt of a CAP Notice. In its proposed CAP, the State shall describe all actions the State and, if applicable, other participants in the Model will take to correct any deficiencies and come into compliance with the terms of this Agreement, including any specific corrective actions required by the relevant provisions thereof. Additionally, in its proposed CAP, the

State shall propose criteria and a process for completion and release of the CAP.

- iv. CMS will review and approve, or require modifications to, the proposed CAP within 30 days of receipt. The CMS-approved CAP will provide criteria and a process for completion and release of the CAP.
 - v. The State shall successfully implement any CAP that is required of the State and approved by CMS no later than 365 days from the receipt of the Warning Notice or by such other time as specified by CMS in writing. Unless the CAP was submitted solely to correct an Other Event, if, after 365 days from the receipt of the Warning Notice or after such time specified by CMS in writing, CMS determines that the CAP has not been implemented successfully, CMS may terminate a Model Program, or the Performance Period of the Model, or this Agreement as described in Section 12.f, or take one or more corrective actions described in Section 12.c.ii. If the CAP was submitted solely to correct an Other Event, if, after 365 days from the receipt of the Warning Notice or after such time specified by CMS in writing, CMS determines that the CAP has not been implemented successfully, CMS may take one or more corrective actions described in Section 12.d.ii.
- c. **Triggering Events.** In the event CMS determines that one or more of the Triggering Events defined in Section 12.c.i has occurred, CMS may take one or more of the corrective actions described in Section 12.c.ii.
- i. **Triggering Event Defined.** A Triggering Event may include, but is not limited to the following:
 - 1. A material breach by the State of any provision of this Agreement.
 - 2. For each Model Year from MY1 until CMS and the State agree upon a Compounded Savings Target, if CMS determines that the State failed to meet the applicable Annual Savings Target defined in Section 6.c by \$100 million or more, as determined in accordance with the methodology described in Section 6.b and Appendix C of this Agreement. CMS and the State may agree to alternative Triggering Events, in conjunction with agreeing upon the Compounded Savings Target methodology.
 - 3. A determination by CMS that the quality of care provided to Medicare, Medicaid, or CHIP beneficiaries has deteriorated.

4. A determination by CMS that the State has taken any action that threatens the health or safety of a Medicare beneficiary or other patient.
 5. A determination by CMS that the State has taken actions that compromise the integrity of the Model or the Medicare Trust Funds.
 6. If the State submits false data or makes false representations, warranties, or certifications in connection with any aspect of the Model.
 7. If the State makes any changes to Md. Code Ann. Health-Gen. §19-201 et seq., and CMS determines, in CMS's sole discretion, that such changes are not consistent with the requirements of this Agreement.
 8. If the State enacts legislation that inhibits the ability of Maryland Payers to participate in the State's health insurance market, and CMS determines, in CMS's sole discretion, that such changes are not consistent with the requirements of this Agreement.
- ii. **Corrective Actions for Triggering Events.** In the event that CMS determines that a Triggering Event (as defined in Section 12.c.i) has occurred, CMS may take one or more of the following corrective actions:
1. require the State to provide additional information to CMS;
 2. subject the State to additional monitoring, auditing or both;
 3. require the State to submit and implement a CAP pursuant to Section 12.b;
 4. add new safeguards or programmatic features;
 5. modify the Model or a Model Program;
 6. make prospective adjustments to payments made to Regulated Maryland Hospitals;
 7. require the State to modify its hospital quality and value-based payment programs described in Section 8.d;
 8. terminate or modify a Medicare payment waiver identified in Appendix G of this Agreement except for those waivers identified in sections (a) and (b) of such Appendix G;

9. terminate the Performance Period of the Model pursuant to Section 12.e;
10. terminate or modify a Model Program and any related Model Program Participation Agreement;
11. terminate this Agreement pursuant to Section 12.f; or
12. with respect to the Triggering Event described in Section 12.c.i.8, CMS may assess the impact on the Model and may require an amendment to this Agreement to address such impact. Any such amendment is not intended to apply to legislation that establishes new physician payment incentives and delivery programs that are consistent with the fair allocation of physician payment based on independent unbiased databases.

d. **Other Events that May Require Corrective Action.** In the event that CMS determines that one or more of the Other Events defined in Section 12.d.i has occurred, CMS may take one or more of the corrective actions described in Section 12.d.ii. An Other Event, by itself, will not lead to termination of the Agreement or the Performance Period of the Model by CMS.

i. **Other Events Defined.** Other Events include, but are not limited to, the following:

1. For each Model Year from MY1 until CMS and the State agree upon a Compounded Savings Target methodology, if CMS determines that the State did not meet the Annual Savings Target defined in Section 6.c by more than \$30 million and less than \$100 million, as determined in accordance with the methodology described in Section 6.b and Appendix C of this Agreement. CMS and the State may agree to alternative Other Events, in conjunction with agreeing upon the Compounded Savings Target methodology.
2. For any Model Year, if CMS determines that the annual growth rate in the Maryland Medicare TCOC per Beneficiary exceeds the TCOC Guardrail defined in Section 6.e.
3. CMS determines that a Model Program is not achieving savings or improving quality.
4. A determination by CMS that the State has failed to demonstrate that the State's hospital quality and value-based payment

program described in Section 8.d achieves or surpasses the measured results in terms of patient outcomes and cost-savings obtained under the programs established under Sections 1886(o), 1886(p), and 1886(q) of the Act.

5. A determination by CMS that the State has failed to meet the Revenue at Risk standard described in Section 8.d.v.
6. A determination by CMS that the State has failed to comply with the conditions associated with one or more Medicare payment waivers described in Section 3.b and Section 5.a.
7. If the State enacts legislation that CMS determines, in CMS's sole discretion, will significantly increase Medicare TCOC in Maryland.
8. A material breach of a CRP Participation Agreement.

ii. **Corrective Actions for Other Events.** If CMS determines that an Other Event has occurred, CMS may undertake one or more of the following corrective actions:

1. Require the State to provide additional information to CMS;
2. Subject the State to additional monitoring, auditing or both;
3. Require the State to submit and implement a CAP pursuant to Section 12.b;
4. With respect to Other Events described in Sections 12.d.i.5 through 12.d.i.7 terminate or modify a Medicare payment waiver identified in Appendix G of this Agreement except for those waivers identified in sections (a) and (b) of such Appendix G.

e. If CMS determines that the State did not achieve the Annual Savings Target defined in Section 6.c.i by any amount, the State shall submit a plan to CMS as part of its annual report in Section 16.b and Appendix D that describes actions to meet the subsequent Model Year's target through adjustments in Maryland's rate-setting system described in Section 8.a, the MPA described in Section 8.c, or other adjustments.

f. **Termination.**

- i. **Termination by CMS.** CMS may immediately or with advance notice terminate a Model Program, a Model Program Participation Agreement,

the Performance Period of the Model, or this Agreement if CMS, in its sole discretion, determines that:

1. the State has not submitted or successfully implemented a required CAP required pursuant to Section 12.b; or
2. the State has not timely complied with a corrective action required by CMS pursuant to Section 12.c.ii.

However, CMS may not terminate this Agreement solely on the grounds that an Other Event has occurred.

- ii. **Termination by the State.** The State may terminate a Model Program, a Model Program Participation Agreement to which the State is a Party, the Performance Period of the Model, or this Agreement at any time for any reason upon 180 days advance written notice to CMS.
- iii. **Termination under Section 1115A(b)(3)(B).** If CMS makes findings under Section 1115A(b)(3)(B) of the Act requiring the termination of the Model, CMS may immediately terminate this Agreement or the Performance Period of the Model.

13. Data Sharing.

- a. **CMS Data Sharing.** CMS will provide MDH and HSCRC with aggregate data and, upon a request made pursuant to Section 13.a.iii, with patient identifiable data, as defined under the HIPAA Privacy Rule at 45 CFR § 164.514(b), that is necessary to enable the State to implement this Agreement.
 - i. **De-Identified Health Information.** CMS will provide the State with the following patient de-identified reports:
 1. Medicare FFS TCOC data for Maryland Medicare Beneficiaries and Medicare FFS Beneficiaries nationwide;
 2. Medicare FFS hospital data for Maryland Medicare Beneficiaries and Medicare FFS Beneficiaries nationwide;
 3. Medicare Part C enrollment data for Maryland and Medicare Part C enrollment nationally;
 4. Data on the usage of non-Maryland hospitals by Maryland Medicare Beneficiaries and data on the usage of Regulated Maryland Hospitals by non-Maryland Medicare Beneficiaries;

5. Data on TCOC and Regulated Maryland Hospital savings by Maryland Medicare Beneficiaries who are dually eligible for the Medicaid program;
 6. Data on the rate of unnecessary hospitalizations by Maryland Medicare Beneficiaries in Regulated Maryland Hospitals and Medicare FFS Beneficiaries nationwide;
 7. Performance data on the Hospital Value-based Purchasing Program for hospitals located in Maryland and nationwide;
 8. Non-Claims Based Payments (as that term is defined in Section 6.b.ii), together with the minimum details necessary to allow cost allocations by Maryland Medicare Beneficiary in accordance with Section 6.b.ii; and
 9. Upon request, and in accordance with applicable law, CMS will provide the State with additional patient de-identified data on Medicare FFS payments, which may include payments to providers and suppliers located outside the state of Maryland and payments broken down by health care provider type and state. CMS will review such requests on a case-by-case basis and will make its best efforts to provide such data in a timely fashion.
- ii. **Health Oversight Agencies.** Appendix E and Appendix F include assertions from the HSCRC and MDH, respectively, as to their status as “health oversight agencies” (as that term is defined in 45 CFR § 164.501) in the context of this Model.
- iii. **Individually-Identifiable Health Information Requests.** The State may request patient identifiable data that is necessary for carrying out a health oversight function under 45 CFR § 164.512(d)(1). All requests for individually-identifiable health information must clearly state the HIPAA basis for the requested disclosure, and an assertion that the data requested constitutes the minimum necessary to carry out that function. 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’s sole discretion. CMS will provide requested data in accordance with applicable law, including HIPAA and the Part 2 regulations governing the use of information regarding diagnosis and treatment of substance abuse.

b. Use and Disclosure of CMS Data.

- i. Appropriate privacy and security protections will be required for any data disclosed under the Model.
 - ii. The State is expected to use the requested data in its efforts to monitor and oversee Maryland'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 patient-identifiable data received under this Agreement to Model participants, including Regulated Maryland Hospitals, to participants in the MDPCP, to participants in the CRP, or to participants in a new Model Program, if such participants have a treatment relationship with the subject(s). 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.
 - iii. Furthermore, notwithstanding any other provision, the State may use the data received under this agreement to create patient de-identified data as that term is understood under the regulations implementing the HIPAA statute, as modified, and may share such patient 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.
 - iv. The HSCRC and MDH agree that any publication or dissemination of purportedly "de-identified" data that is derived from the CMS data received in accordance with Section 13.a must adhere to CMS's current cell size suppression policy. This policy stipulates that no cell (e.g., admittances, discharges, patients, services) representing 10 or fewer beneficiaries may be displayed. Also, no use of percentages or other mathematical formulas may be used if they result in the display of a cell representing 10 or fewer beneficiaries.
- c. **State Data Sharing.** In accordance with 42 CFR § 403.1110, the State shall supply all-payer hospital spending data and population health outcomes, access and quality metric data on an annual basis to CMS to support CMS monitoring and evaluation of the Model, and shall retain such documentation in accordance with Section 18. The State will ensure that such data include Medicaid and commercial plan claims data from Maryland Payers, exclusive of ERISA plans, to support CMS monitoring and evaluation of the Model, to the extent allowed by law and the written agreements between the State and each such payer. The State may provide these data from a combination of sources, including State data

systems, Regulated Maryland Hospitals, Medicaid plans, or commercial plans. CMS may use this data to conduct analyses and may publish the data and analyses in de-identified form.

14. Monitoring.

- a. **Medicare Beneficiary Protections.** The State and CMS shall ensure that Medicare beneficiaries' access to items, services, providers and suppliers will not be limited by the implementation of the Model. Specifically, the State and CMS will ensure that Maryland 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. Maryland Medicare Beneficiaries will not experience any reductions in their rights to benefits or covered services under this Agreement.
- b. **CMS Monitoring Activities.** CMS will conduct monitoring activities to assess the State's compliance with the terms of this Agreement.
 - i. Such monitoring activities will be conducted with reasonable notice to the State, and may include, without limitation:
 1. Interviews with any State employees or agents involved in operating or administering the Model;
 2. Audits of regulatory actions taken by the State, implementation plans, CAPs, and other data from the State;
 3. Site visits to the State, Regulated Maryland Hospitals, MDPCP participant practices, MDPCP CTOs, CRP Care Partners, and community stakeholders; and
 4. Documentation requests sent to the State.
 - ii. CMS shall, to the extent practicable and as soon as 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 shall notify the State within 15 days of altering such schedule, and shall take into consideration the

schedule of the State's staff, and attempt to reschedule announced audits at a mutually agreeable time.

3. The State shall cooperate with all CMS monitoring and oversight requests and activities in accordance with 42 CFR § 403.1110.

c. **State Monitoring Activities.** In addition to the requirements set forth in Section 9.h, the State shall follow ongoing monitoring procedures in accordance with Appendix D of this Agreement to monitor Regulated Maryland Hospitals and the State's performance under the Model.

- i. The State shall report any issues to CMS no later than 30 days after identification and, if applicable, submit a CAP to address these issues in accordance with Section 12.b of this Agreement.
- ii. The State must submit reports to CMS regarding its monitoring of the Model, in accordance with Appendix D of this Agreement and regarding its monitoring of the CRP, in accordance with Section 9.h of this Agreement. The State shall also provide CMS with records relating to its monitoring efforts and findings at CMS's request, and will make available to CMS the State's datasets and methodologies used for purposes of preparing such monitoring reports.

15. Quality Payment Program.

- a. CMS and the State intend for the Hospital Payment Program described in Section 8, together with the CRP described in Section 9, to remain an Advanced Alternative Payment Model ("**Advanced APM**") for purposes of the Quality Payment Program. CMS and the State also intend for hospitals participating in the Hospital Payment Program and the CRP to be the participating APM entities, and for Care Partners participating in the CRP to be identified on an Affiliated Practitioner List that identifies the eligible clinicians who could become Qualifying APM Participants (QPs).
- b. CMS and the State also intend for the MDPCP to remain an Advanced APM for the participating practices to be the participating APM Entities, and for the physicians and other eligible clinicians identified on a Participant List for the MDPCP to be the eligible clinicians who could become QPs through participation in the MDPCP.

- c. Notwithstanding Section 17.a, CMS may make unilateral amendments to this Agreement, as needed, to ensure that the Model meets the criteria to be an Advanced APM.

16. Model Evaluation.

- a. **CMS Evaluation.** CMS will monitor and evaluate the Model in accordance with Section 1115A(b)(4) of the Act, and compare the model to costs, quality and outcomes observed nationwide for the Medicare program in other states.
 - i. The State and its agents shall cooperate with CMS and/or CMS's designee(s) and provide all data needed by CMS to evaluate and monitor the Model in accordance with applicable law and this Agreement. Such data may include, but would not be limited to, individually identifiable health information that is needed to carry out CMS's evaluation and monitoring of this Model.
 - ii. The State must ensure the production of such data through statutory or regulatory mandates on entities holding the required data, or through alternative legal arrangements. 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's designee(s) is entitled to access individual-level, identifiable data to carry out evaluation and monitoring activities. See 42 CFR § 403.1110.
 - iii. The State, its contractors and participants in the Model must submit all data required for the monitoring and evaluation of this Model, which may include the terms of any arrangements related to rate-setting or payment entered into between the State and Regulated Maryland Hospitals prior to or during the Model.
 - iv. CMS shall have the authority to share all Model data, documents, and other information with its designees for evaluation, monitoring, oversight, and other purposes, in accordance with applicable law. CMS shall have the authority to use any data obtained pursuant to the Model to publicly disseminate quantitative and qualitative results, in accordance with applicable law.
- b. **State Evaluation.** The State shall submit to CMS progress reports in accordance with the requirements of Appendix D of this Agreement. The State must make available to CMS and CMS's 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. Any information provided to CMS will be used by CMS solely for the purposes described in the Agreement or to ensure compliance with this Agreement and applicable law.

17. Modification.

- a. The Parties may amend the Agreement, including any Appendix hereto, at any time by mutual written consent. In addition, 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 Maryland law, regulatory requirements, accreditation standards or licensing guidelines or rules. CMS shall include with any such amendment an explanation of the reasons for the amendment.
- b. To the extent practicable, CMS shall provide the State with 30 days advance written notice of any such unilateral amendment, which notice shall specify the amendment's effective date. If the law of the State precludes application of the amendment to the Agreement, 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 Model and/or any waivers in accordance with Section 12.e of the Agreement.

18. Maintenance of Records.

- a. In accordance with applicable law, the State shall maintain and make available to CMS, HHS, the Department of Justice, the Comptroller General, and other federal agencies or their designees access to all books, contracts, records, documents, software systems, and other information (including data related to calculations required under the Agreement, Medicare utilization and costs, and quality performance measures) sufficient to enable the audit, evaluation, inspection, or investigation of the State's compliance with the requirements of this Agreement.
- b. The State shall 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.

19. Preclusion.

- a. The State acknowledges and understands that Section 1115A(d)(2) of the Act precludes from administrative and judicial review under Sections 1869 and 1878 of the Act, or otherwise:
 - i. the selection of models for testing or expansion under Section 1115A of the Act;
 - ii. the selection of organizations, sites, or participants to test those models selected;
 - iii. the elements, parameters, scope, and duration of such models for testing or dissemination;
 - iv. determinations regarding budget neutrality under Section 1115A(b)(3) of the Act;
 - v. the termination or modification of the design and implementation of the Model under Section 1115A(b)(3)(B) of the Act; and
 - vi. determinations about expansion of the duration and scope of a model under Section 1115A(c) of the Act, including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection.
- b. For purposes of this preclusion from administrative and judicial review, the State acknowledges and understands that the elements and parameters of the Model include, without limitation:
 - i. the methodologies and calculations used to determine the State's performance against the Model Financial Targets and other terms and conditions of the Agreement; and
 - ii. the transition of Regulated Maryland Hospitals to payment under the national Medicare FFS program, if applicable.

20. Miscellaneous.

- a. **Survival.** Termination or expiration of a Model Program shall not affect the rights and obligations of the Parties accrued under the Agreement prior to the

effective date of termination or expiration of the Model Program, including obligations regarding submission of reports and other data, monitoring and evaluation activities, and cooperation with monitoring and evaluation activities.

- b. **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 shall not affect any other provisions of this Agreement, and this Agreement shall 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.
- c. **Severability of Model Programs.** In the event a Model Program is terminated, other Model Programs may continue, so long as they continue to meet their requirements specified in this Agreement and the applicable Model Program Participation Agreement.
- d. **Entire Agreement.** This Agreement, including all Appendices, constitutes the entire agreement between the Parties. The Parties may amend this Agreement or any Appendix hereto pursuant to Section 17 except as otherwise noted in this Agreement or any Appendix hereto.
- e. **Precedence.** If any provision of this Agreement conflicts with a provision of any documents incorporated herein by reference, the provision of this Agreement shall prevail.
- f. **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.
- g. **Notice.** All notices, requests, and correspondence required or permitted by this Agreement shall be in writing and sent to the below listed addresses:

To the State:
Office of Secretary
Robert.Neall@maryland.gov or successor
Maryland Department of Health
Herbert R. O'Connor State Office Building
201 West Preston Street
Baltimore, MD 21201-2399

Nelson Sabatini or successor
Chair
c/o Donna.kinzer@Maryland.gov or successor
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

To CMS:
Dawn Alley or successor
Director, State Innovations Group
Center for Medicare and Medicaid Innovation
Dawn.Alley@cms.hhs.gov or successor 2810 Lord Baltimore Drive
Windsor Mill, MD 21244

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

[SIGNATURE PAGE FOLLOWS]

Each Party is signing this Agreement on the date stated above that Party's signature. If a Party signs but fails to date a signature, the date that the other Parties receive the signing Party's signature will be deemed to be the date that the signing Party signed this Agreement.

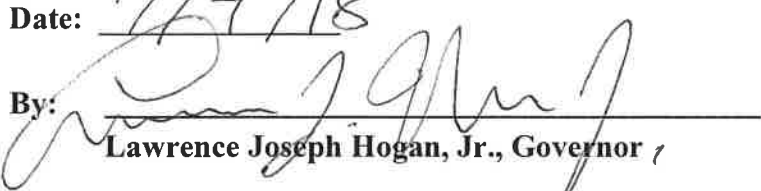
CENTERS FOR MEDICARE & MEDICAID SERVICES

Date: 7/17/18

By: 
Adam Boehler, Director, Center for Medicare and Medicaid Innovation


GOVERNOR OF MARYLAND

Date: 7/9/18

By: 
Lawrence Joseph Hogan, Jr., Governor

MARYLAND DEPARTMENT OF HEALTH

Date: 7/9/2018

By: 
Robert R. Neall, Secretary of Health

HEALTH SERVICES COST REVIEW COMMISSION

Date: 7/9/2018

By: 
Nelson Sabatini, Chairman

Appendix A: Maryland Hospital Facilities and Revenue Regulation Status

This Appendix A lists Regulated Maryland Hospitals for which Medicare FFS pays each such hospital on the basis of the rates set by the State for the hospital.

The parties hereby agree to propose mutually agreeable updates to this listing as necessitated by changes to Maryland hospitals' census or status, and agree to use any such update(s) for purposes of this Model in lieu of this Appendix A.

Medicare Provider Number	Hospital Name	Type
210001	Meritus Medical Center	Acute-General
210002	University of Maryland (UM) Medical Center	Acute-General
210003	UM – Prince George's Hospital Center	Acute-General
210004	HCH – Holy Cross Hospital	Acute-General
210005	Frederick Memorial Hospital	Acute-General
210006	UM – Harford Memorial Hospital	Acute-General
210008	Mercy Medical Center	Acute-General
210009	JHHS – Johns Hopkins Hospital	Acute-General
210010	UM – Shore Regional Health at Dorchester	Acute-General
210011	St. Agnes Hospital	Acute-General
210012	LifeBridge – Sinai Hospital	Acute-General
210013	Bon Secours Hospital	Acute-General
210015	MedStar Franklin Square Medical Center	Acute-General
210016	Adventist – Washington Adventist Hospital	Acute-General
210017	Garrett County Memorial Hospital	Acute-General
210018	MedStar Montgomery Medical Center	Acute-General
210019	Peninsula Regional Medical Center	Acute-General
210022	JHHS – Suburban Hospital	Acute-General
210023	Anne Arundel Medical Center	Acute-General
210024	MedStar Union Memorial Hospital	Acute-General
210027	Western Maryland Regional Medical Center	Acute-General
210028	MedStar St. Mary's Hospital	Acute-General
210029	JHHS – Johns Hopkins Bayview Medical Center	Acute-General
210030	UM – Shore Regional Health at Chestertown	Acute-General
210032	Union Hospital of Cecil County	Acute-General
210033	LifeBridge – Carroll Hospital Center	Acute-General
210034	MedStar Harbor Hospital	Acute-General
210035	UM – Charles Regional Medical Center	Acute-General

Medicare Provider Number	Hospital Name	Type
210037	UM – Shore Regional Health at Easton	Acute-General
210038	UM – Midtown Campus	Acute-General
210039	Calvert Health Medical Center	Acute-General
210040	LifeBridge – Northwest Hospital Center	Acute-General
210043	UM – Baltimore Washington Medical Center	Acute-General
210044	Greater Baltimore Medical Center	Acute-General
210045	McCready Memorial Hospital	Acute-General
210048	JHHS – Howard County General Hospital	Acute-General
210049	UM – Upper Chesapeake Medical Center	Acute-General
210051	Doctors Community Hospital	Acute-General
210055	UM – Laurel Regional Hospital	Acute-General
210056	MedStar Good Samaritan Hospital	Acute-General
210057	Adventist – Shady Grove Adventist Hospital	Acute-General
210058	UM – Rehabilitation & Orthopaedic Institute	Acute-General
210060	Fort Washington Medical Center	Acute-General
210061	Atlantic General Hospital Corporation	Acute-General
210062	MedStar Southern Maryland Hospital Center	Acute-General
210063	UM – St. Joseph Medical Center	Acute-General
210064	LifeBridge – Levindale Hebrew Geriatric Center and Hospital	Acute-General
210065	HCH – Holy Cross Germantown Hospital	Acute-General
210087	Adventist – Germantown Emergency Center	Freestanding Emergency (FSE)
210088	UM – Queen Anne’s Freestanding Emergency Center	FSE
210333	UM – Bowie Health Center	FSE
218992	UM – Shock Trauma	Acute-General

Appendix B: Specifications for Calculating the All-Payer Revenue Limit

I. Definitions

“**All Payers**” refers to both Medicare FFS and Maryland Payers.

“**Base Period**” means calendar year 2013.

“**Base Period Revenue**” equals the Regulated Gross Patient Service Revenue during the Base Period.

“**Growth Limit**” means the percentage cap on the annual growth in revenue to Regulated Maryland Hospitals from All Payers. The Growth Limit is 3.58 percent.

“**Population Growth Percentage**” means the percentage increase in Maryland’s population for a Model Year based on population growth estimates from the Maryland Department of Planning.

“**Regulated Gross Patient Service Revenue**” means gross revenue from All Payers for the treatment of Maryland residents by Regulated Maryland Hospitals.

II. Calculating the All-Payer Revenue Limit

The State will calculate the All-Payer Revenue Limit according to the following steps:

- 1) For each calendar year from 2013 through 2026, the State will calculate a compounding factor equal to $(1 + \text{the Growth Limit for that Model Year})$ multiplied by $(1 + \text{the Population Growth Percentage for that Model Year})$ (“**Compounding Factor**”).
- 2) For a given Model Year, the Base Period Revenue will be multiplied by the Compounding Factor, as defined in II.1 of this Appendix B, for every calendar year between and including the Base Period and the current Model Year, to yield the maximum revenue that Regulated Maryland Hospitals may earn in that Model Year from All Payers (“**All-Payer Revenue Limit**”).

III. Reporting of Regulated Gross Patient Service Revenue

- 1) The State must report Regulated Gross Patient Service Revenue for each Model Year and Regulated Gross Patient Service Revenue during the Base Period in a consistent manner, except as provided in Section III.2 of this Appendix B.
- 2) The State may adjust Regulated Gross Patient Service Revenue for a Model Year to reflect an increase in the Public Payer Differential proposed by the State and approved by CMS pursuant to Section 8.b of the Agreement.

IV. All-Payer Per Capita Total Hospital Payment Amount Calculation

By May 1 of each Model Year, beginning in MY2, the State will divide the Regulated Gross Patient Service Revenues for the prior Model Year by the most recently available population estimates for the State of Maryland at the time of the calculation to calculate the All-Payer per Capita Total Hospital Payment Amount.

Appendix C: Specifications for Calculating the Annual Medicare Savings

1. CMS will calculate the Maryland Medicare TCOC per Beneficiary by adding together the following two fractions: (a) Medicare Part A expenditures per Maryland Medicare Beneficiary with Part A; and (b) Medicare Part B expenditures per Maryland Medicare Beneficiary with Part B. CMS will calculate the National Medicare TCOC per Beneficiary by adding together the following two fractions: (a) Medicare Part A expenditures per Medicare FFS Beneficiary with Part A; and (b) Medicare Part B expenditures per Medicare FFS Beneficiary with Part B.

- a) The calculation of the Maryland Medicare TCOC per Beneficiary will include: (1) all Part A and Part B expenditures for Maryland Medicare Beneficiaries, regardless of the state of service, including payments made under the MDPCP (in accordance with Section 6.b.ii of the Agreement); (2) CMS-approved Outcomes-Based Credits up to the amount of CMFs paid by CMS to MDPCP participants (in accordance with Section 6.b.ii); (3) if applicable, other investments in Model Programs against which the Outcomes-Based Credits may apply, if approved by CMS (in accordance with Section 7.b); and (4) adjustments to account for historical performance against the Annual Savings Targets (in accordance with Section 6.b.i).
- b) The calculation of both the Maryland Medicare TCOC per Beneficiary and the National Medicare TCOC per Beneficiary will include Non-Claims Based Payments (in accordance with Section 6.b.ii of the Agreement).
- c) Annual per-beneficiary Part A expenditures will be calculated as the sum of the 12 months of monthly Part A expenditures for beneficiaries enrolled in Part A during that month, divided by the average monthly enrollment in Part A for that year.
- d) Annual per-beneficiary Part B expenditures will be calculated as the sum of the 12 months of monthly Part B expenditures for beneficiaries enrolled in Part B during that month, divided by the average monthly enrollment in Part B for that year.

2. CMS will calculate the Annual Medicare Savings, defined in Section 6.b of the Agreement, as follows:

- a) Separately for Medicare Part A and Part B:
 - i) For each Model Year during the Performance Period of the Model, CMS will use a baseline of the Maryland Medicare TCOC per Beneficiary for calendar year 2013, calculated based on the specifications in Section 1 of this Appendix C, which will be trended forward by the compound annual growth rate in National Medicare TCOC per Beneficiary, calculated based on the specifications in section 1 of this Appendix C, to calculate the TCOC benchmark for that Model Year.

- ii) CMS will then calculate a per-beneficiary savings amount, which will be the difference between the Model Year's benchmark, calculated in accordance with Section 2.a.i of this Appendix C, and the Maryland Medicare TCOC per Beneficiary for that Model Year, calculated in accordance with section 1 of this Appendix C.
 - iii) The total savings amount will be the per-beneficiary savings amount, calculated in accordance with Section 2.a.ii of this Appendix C, multiplied by the sum of:
 - (1) Average monthly enrollment in the applicable Part (Part A or Part B) for the Model Year; and
 - (2) The increase, if any, in average monthly enrollment in Part C for the Model Year, compared to average monthly enrollment in Part C in the prior Model Year.
- b) CMS will calculate the Annual Medicare Savings as the sum of the total savings amount calculated under Section 2.a of this Appendix C for Part A and Part B for the Model Year and adjusted for Exogenous Factors.
3. Non-Claims Based Payments will be counted as costs beginning in MY2 (2020), based on MY1 (2019) performance. The lag will help ensure that the State has adequate notice of the amounts.
 4. CMS will share with the State the details of the methodology to be used for the Annual Medicare Savings calculation, including how any Non-Claims Based Payments are incorporated into both the Maryland Medicare TCOC per Beneficiary and the National Medicare TCOC per Beneficiary calculations.
 5. CMS and Maryland understand that Medicare billing rules and requirements may change over the course of the Model. Consistent with Section 17 of this Agreement, CMS and Maryland may amend this Agreement to modify the savings calculation methodology described in this Appendix C. CMS will make available data used for this calculation as specified in Section 6 of the Agreement.
 6. The State and CMS will continue to calculate hospital savings, recognizing that investments will be made in non-hospital settings to produce hospital savings. This effort will inform CMS's determination pursuant to Section 11 and Section 12 of this Agreement as to whether to add, modify, or eliminate Model Programs as needed, based on the hospitals' performance.

Appendix D: State Monitoring Plan and Reporting Requirements

During each Model Year, the State will submit to CMS in a form and manner specified by CMS:

- A report by June 30 that catalogs the State's performance with respect to the health care expenditures described below for the previous Model Year; and
- A report by December 31 that catalogs the State's performance with respect to the quality described below.

Additionally, Regulated Maryland Hospitals will remain subject to the reporting requirements under Medicare's Hospital Inpatient Quality Reporting (IQR) and Hospital Outpatient Quality Reporting (OQR) programs. The State will include the performance of Regulated Maryland Hospitals on the applicable IQR and OQR measures.

Maryland Regulated Rates for Maryland Payers and Medicare

The State will report on the total Regulated Revenue and growth rate in total Regulated Revenue for each Regulated Maryland Hospital.

Maryland Monitoring Plan and Reporting Requirements

The State will monitor its methods used to continuously improve quality and outcomes, and will also measure and monitor its financial outcomes under the Model. Such monitoring must be conducted throughout each Model Year. The State will provide a summary of its monitoring activities and the findings from such monitoring activities to CMS in the reports submitted on June 30 and December 31 of each Model Year, listed above. The State will make available to CMS, upon request, the Maryland datasets, methodologies, and audits used for purposes of these monitoring activities to the extent permitted by law. Table 1 of this Appendix D outlines measure details and data sources that must be included in such reports, when available.

- **Patient experience of care:** The State will measure patient satisfaction, the effectiveness of care transitions, physician participation in public programs, hospital process of care measures, and measures of hospital care (e.g., readmissions and complications).
- **Population Health:** At minimum, the State will report on all measures included in the State Health Improvement Process (SHIP) such as avoidable admissions and emergency department visits, and measures related to population health goals under consideration for Outcomes-Based Credits.
- **Health care expenditures:** The State will measure inpatient and outpatient cost trends, and all-payer TCOC for all Maryland residents. The State will track expenditures for specific payers, including Medicare and Medicaid, among other payers for which data are available, exclusive of ERISA plans.

Table 1.

Goal		Measure	Data Source	Considerations/Comments
1	Increase Patient Satisfaction – Hospital	Relevant and publicly reported HCAHPS measures.	Survey; Hospital Compare	
2	Increase Patient Satisfaction – Home Health	Relevant and publicly reported HHCAHPS measures.	Survey; Home Health Compare	The State will monitor measures and consider the addition of improvement targets in the future.
3	Increase Patient Satisfaction – Nursing Homes	Relevant and publicly reported Nursing Home Patient Satisfaction measures, to align with NHCAHPS.	TBD	As data source becomes available, report on Patient Satisfaction in Nursing Homes. Maryland will also consider transitioning to NHCAHPS survey as it becomes available.
4	Increase Patient Satisfaction – Ambulatory Care	Clinician and Group CAHPS: Patient perception of care provided by a physician in an office.	Survey	The State will monitor CG-CAHPS measures and consider the addition of improvement targets in the future.
5	Enhance Care Transitions – Hospital	Relevant and publicly reported measures of Care Transitions from the Hospital.	TBD	The State will monitor and report relevant and publicly reported measures of Care Transitions from the Hospital.
6	Enhance Care Transitions – Coordination with Primary Care; Other settings of Care	Rate of Physician Follow-up after Discharge; Hospital stays with ambulatory care provider notified.	Claims	The State will monitor and report measures for which there is available, reliable data.
7	Sustain Physician Participation in Public Programs	Medicaid participating physicians per Medicaid beneficiary; Medicare participating physicians per Medicare beneficiary.	CMS; Maryland Department of Health	
8	Broaden Engagement in	Provider participation in innovative models of care.	TBD	The State will monitor and report provider participation in innovative models of care.

	innovative models of care	Provider Participation in Maryland Primary Care Program (MDPCP).		
9	Improve Process of Care – Inpatient	State performance on relevant and publicly available IQR process of care measures.	IQR; Hospital Compare	The State will monitor and report process measures of particular relevance and significance under IQR.
10	Improve Process of Care – Outpatient	State performance on relevant and publicly available OQR process of care measures.	OQR; Hospital Compare	The State will monitor and report process measures of particular relevance and significance under OQR.
11	Improve Inpatient Care – Hospital-Acquired Complications	Relevant measures of Hospital-Acquired Complications.	NHSN; HSCRC Hospital IP Discharge Abstract	The State will monitor and report measures of hospital-acquired complications.
12	Reduce Readmissions	All-Cause Readmissions; Readmissions per 1,000 residents.	HSCRC Hospital IP Discharge Abstract	
13	Reduce Readmissions from various Post-Discharge settings	Readmissions from Home Health; Readmissions from Nursing Homes.	Home Health Compare; HSCRC Hospital IP Discharge Abstract	The State will monitor and report measures of readmissions from various Post-Discharge settings using publicly available data source or HSCRC data with discharge disposition flag.
14	Reduce Readmissions – Condition-specific	Readmissions by condition, where a valid measure of condition-specific definition is available.	HSCRC Hospital IP Discharge Abstract	The State will monitor and report condition-specific readmission rates.
15	Reduce Potentially Avoidable Hospital Admissions	Prevention Quality Indicator (PQI) composite of potentially avoidable hospital admissions.	HSCRC	Preventable hospitalizations per 100,000 population. Other definitions and measures of potentially avoidable admissions may be developed and monitored over time.

16	Reduce Potentially Avoidable ED Visits	ED Visit Rates per 1,000 residents by relevant conditions.	HSCRC	The State will monitor and report condition-specific ED visits, where data is relevant and publicly available.
17	Other SHIP Measures of Population Health	SHIP measures of Population Health.	MD SHIP	The State will monitor and report SHIP measures of population health.
18	Progress toward Population Health Goals	Prevalence, incidence, and mortality for conditions as related to the population health goals submitted for credit under the Model.	TBD	The State will monitor and report on measures as described in specific measure documents submitted through CMS.
19.a	Control Expenditure Growth – Hospital	Per capita hospital charges and expenditure growth (inpatient and outpatient) by payer category for which there is available and reliable data.	HSCRC Hospital IP and OP Discharge Extract; Public Program Enrollment Files	The State will monitor and report measures of per capita hospital expenditures.
19.b	Control Expenditure Growth – All Health Services	Per capita health expenditures and expenditure growth (hospital and non-hospital) by payer category for which there is available and reliable data.	Claims, where available	Medicare and Medicaid; Other data sources where available.
20	Other Financial Measures	Relevant and publicly available financial measures, as applicable.	TBD	The State will monitor and report relevant and publicly available financial measures, as applicable.

Appendix E: HSCRC's Role as a Health Oversight Agency Assertion

[Attached hereto]

State of Maryland
Department of Health



Nelson J. Sabatini
Chairman

Joseph Antos, PhD
Vice-Chairman

Victoria W. Bayless

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Gerard J. Schmith, Director
Revenue & Regulation
Compliance

Date: July 2, 2018

To: The Total Cost of Care Model

From: Health Services Cost Review Commission (HSCRC)

Re: Appendix E, Total Cost of Care Model State Agreement

HSCRC's Role as a Health Oversight Agency

The HSCRC is an independent Maryland state agency, properly authorized by State law to oversee the hospital health care system by approving reasonable rates that enable hospitals to provide their services effectively and efficiently. Since its inception, the primary mission of the HSCRC has been to contain costs while improving quality of care and enhancing access to needed hospital services. The federal government has long recognized the role played by the HSCRC in overseeing the hospital health care system in Maryland by having granted the State a waiver of national Medicare reimbursement principles in favor of HSCRC rate setting.^[1] Because of the role it plays vis-à-vis the Maryland hospital health care system, the HSCRC is a health oversight agency as defined by HIPAA.^[2]

[1] In general, the HSCRC has rate-setting "jurisdiction over hospital services offered by or through all facilities." Md. Code Ann., Health-General §19-211(a)(1). Its duties in exercising this jurisdiction constitute health oversight activities. They include, for example: 1) maintaining the Medicare Waiver as part of its oversight of the hospital health care system; 2) assuring all patients that rates are reasonably related to costs and are set equitably without undue discrimination (Md. Code Ann., Health-General §19-212(5)(iii)); 3) investigating "any matter that relates to the cost of services" in hospitals (Md. Code Ann., Health-General §19-225(a); 4) monitoring the financial condition of regulated facilities (Md. Code Ann., Health-General §19-212(3); and 5) overseeing hospitals' compliance with miscellaneous patients' rights' laws – e.g., reviewing each hospital's implementation of and compliance with Maryland's rules for collection of hospital bad debt (Md. Code Ann., Health-General §19-214.2(h)). In carrying out these roles, and as specifically contained in the All-Payer Model Agreement with CMS, Maryland also oversees the hospital quality programs and value-based purchasing programs for Medicare beneficiaries and all patients in Maryland hospitals. The All-Payer Model Agreement is referenced in the HSCRC statute (Health General Article, §19-219(b) and (c)). Under the Amendment that was approved to the All-Payer Model in October 2016, Maryland will also oversee the care redesign programs that focus on care coordination, hospital care improvement, and chronic and complex care improvement, all of which involves Regulated Maryland Hospitals and their Care Partners.

[2] A Health oversight agency is defined as "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

We believe that the HIPAA Privacy rule permits the disclosure of protected health information (“PHI”) by covered entities such as CMS’ Medicare Fee for Service Program to health oversight agencies when such entities require the information to conduct statutory or regulatory assigned “oversight activities,” such as criminal, civil, and administrative investigations, proceedings, or actions, audits, licensure or disciplinary actions, inspections, and audits. Oversight activities also include "other activities necessary for appropriate oversight of, among other things: (i) the health care system; (ii) Government benefit programs for which health information is relevant to beneficiary eligibility; (iii) Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or (iv) Entities subject to civil rights laws for which health information is necessary to determine compliance."^[3] There is nothing in the definition of a health oversight agency or the ability of covered entities to disclose information to a health oversight agency that requires a showing that the health oversight agency has any particular authority over a covered entity from which it requests information—just a requirement that it ask for only the minimum necessary information needed for the purpose behind the request.

CMS understands that HSCRC has asserted that it believes that CMS may properly disclose the information requested to the HSCRC. The information is necessary for the Commission to carry out its functions to oversee Maryland's hospital health care system under 45 CFR 164.512(d)(1)(i), which allows disclosure of PHI to health oversight agencies for "activities necessary for appropriate oversight of . . . the health care system." CMS therefore understands HSCRC to be asserting that the Medicare FFS information is necessary to meet the goals of improved health, improved care, and reduced costs for Medicare beneficiaries in the State.

CMS further understands that HSCRC believes that the information will enable the HSCRC help facilitate coordinated care and to analyze claims and administrative data, stratify the population, follow treatment and payment across the health care spectrum (in order to monitor compliance with applicable law and this Model Agreement). According to HSCRC’s assertions, CMS understands that the coordination of care, including the linking of Medicare claims with other clinical and administrative data and the sharing of the data with hospitals and other covered entities for this purpose, qualifies as a “necessary” health oversight activity under HIPAA for achieving the aims coveted by both the federal government and the State of Maryland.

By: Donna Kinzer
Donna Kinzer
Executive Director

Date: July 2, 2018

(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." 45 CFR § 164.501.

[3] 45 CFR § 164.512(d)(1).

Appendix F: MDH as a Health Oversight Agency Assertion

[Attached hereto]



MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

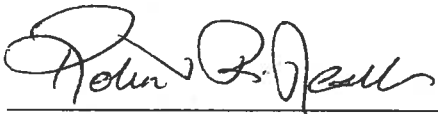
MDH as a Health Oversight Agency Assertion

Title 2, subtitle 1 of the Health-General Article of the Annotated Code of Maryland establishes the Maryland Department of Health (“MDH”) as a principal department of State government. MDH has the legal authority under Titles 2 and 15 of the Health-General Article to oversee the Maryland health care system generally and to promote and guide the development of physical and behavioral health care for the State. The Secretary of Health, appointed by the Governor with the advice and consent of the Senate, is the head of MDH. Md. Code Ann., Health-Gen’1 § 2-102. The Secretary establishes “general policy for, and adopt[s] standards to promote and guide the development of,” health services in the State and is responsible “for the health interests of the people of this State and shall supervise generally the administration of the health laws of this State.” Health-Gen’1 § 2-105. The Secretary is authorized to establish areas of responsibility in MDH to fulfill the Secretary’s assigned duties, Health-Gen’1 § 2-102(b)(2), and also may “apply for, receive, and spend ... federal funds made available to the Department for use in carrying out the powers and duties of the Secretary or the Department.” Health-Gen’1 § 2-104(i).

The Secretary’s statutory authority supports MDH’s application to the federal government for the creation of a primary care program as well as other care delivery transformation programs. In addition, the Secretary may create “any advisory council that the Secretary considers necessary and assign appropriate functions to it.” Health-Gen’1 § 2-104(d). This provision permits the Secretary to create an advisory council to oversee the implementation of the primary care program (i.e., the MDPCP). The authority given to the Secretary in section 2-108 of the Health-General Article provides further support for the creation of the MDPCP as well as any decision to contract with other entities to perform various functions of the MDPCP and the Model as a whole. This section authorizes the Secretary to identify deficiencies in health care services and facilities in the State, develop plans to address those deficiencies, and enter into contracts with public or private entities to address the deficiencies.

Finally, the statute establishing the Maryland Medical Assistance Program, which is administered by the Secretary, provides that “it is a goal of this State to promote the development of a health care system that provides adequate and appropriate health care services to the indigent and medically indigent individuals.” Health-Gen’1 § 15-102.1(a). The statute also authorizes MDH to provide preventative and home care services for these individuals and to promote educational opportunities for recipients of its services. Health-Gen’1 § 15-102. The MDPCP and other Model Programs will assist MDH in fulfilling these responsibilities.

In summary, because of the oversight role that MDH is authorized to play vis-à-vis the entire State health care system, MDH is a “health oversight agency” within the meaning of 45 CFR § 164.501. To carry out its responsibilities as a health oversight agency under this Agreement, the disclosure of personally identifiable health information may be necessary to determine program compliance in the existing Model Programs as well any proposed under section 12 of this Agreement. Because MDH is a health oversight agency for purposes of this Agreement, CMS may properly disclose the individually identifiable health information that MDH requests to the extent that such information represents the minimum information needed for the health oversight purpose behind the request.

By: 

Robert R. Neall
Secretary of Health

Date: 6/29/18

Appendix G: Medicare Payment Waivers

- a. **Inpatient Prospective Payment System (IPPS).** CMS waives Sections 1886(d), 1886(g), and 1886(b)(1) of the Act and implementing regulations at 42 CFR 412, subparts A through M, only insofar as necessary for the purposes of testing this Model during the Agreement Term and only insofar as the State remains in compliance with the terms of this Agreement.
- b. **Outpatient Prospective Payment System (OPPS).** CMS waives Section 1833(t) of the Act and implementing regulations at 42 CFR Part 419, insofar as necessary for the purposes of testing this Model during the Agreement Term and only insofar as the State remains in compliance with the terms of this Agreement. Provisions waived include those pertaining to outpatient psychiatric services and those in Section 603 of the Bipartisan Budget Act of 2015, also pursuant to 42 CFR § 419.20 and 81 Federal Register 45614, as well as those outpatient services excluded from OPPS as described in 42 CFR § 419.22.
- c. **Medicare Hospital Readmissions Reduction Program.** CMS waives Section 1886(q)(1)-(5) of the Act and implementing regulations at 42 CFR §§ 412.152 and 412.154, insofar as necessary for the purposes of testing this Model during the Agreement Term and only insofar as the State remains in compliance with the terms of this Agreement.
- d. **Medicare Hospital Acquired Conditions Program.** CMS waives section 1886(p)(1)-(4) of the Act and implementing regulations at 42 CFR § 412.172, insofar as necessary for the purposes of testing this Model during the Agreement Term and only insofar as the State remains in compliance with the terms of this Agreement.
- e. **Medicare Hospital Value Based Purchasing (VBP) Program.** CMS waives Section 1886(o)(1)-(9) of the Act, and implementing regulations at 42 CFR § 412.160, et seq., insofar as necessary for the purposes of testing this Model during the Agreement Term and only insofar as the State remains in compliance with the terms of this Agreement.
- f. **Medicare Electronic Health Record (EHR) Incentive Program.** CMS waives Section 1886(b)(3)(B)(ix)(I) of the Act, and implementing regulations at 42 CFR § 412.64, during the Agreement Term only insofar as necessary for the purposes of testing this Model and only insofar as the State remains in compliance with the terms of this Agreement, and provided that each Regulated Maryland Hospital is an eligible hospital (as defined in Section 1886(n)(6)(B) of the Act and the implementing regulations at 42 CFR § 495.4) that is a

meaningful EHR user (as defined in Section 1886(n)(3) of the Act and the implementing regulations at 42 CFR § 495.4). The HSCRC shall ensure that Regulated Maryland Hospitals meet the criteria specified in 42 CFR § 414.1415(a)(1)(i).

- g. Continuation of IME/GME Exceptions Provided to Regulated Maryland Hospitals.** CMS shall continue to apply the requirements of the following Medicare provisions with respect to Regulated Maryland Hospitals.

 - i. The Secretary shall continue to establish the rules for the application of Section 1886(d)(11) of the Act to Regulated Maryland Hospitals participating under this Model in the same manner as it would apply to the hospital if it were a hospital paid under Section 1814(b)(3) of the Act.
 - ii. The Secretary shall continue to establish the rules for the application of Section 1886(h)(3)(D) of the Act to Regulated Maryland Hospitals participating under this Model in the same manner as it would apply to the hospital if it were a hospital paid under Section 1814(b)(3) of the Act.
- h. Payment for Outpatient Therapy Services and Comprehensive Outpatient Rehabilitation Services.** CMS waives Section 1834(k) of the Act, during the Agreement Term only insofar as necessary for the purposes of testing this Model and only insofar as the State remains in compliance with the terms of this Agreement.
- i. Psychiatric Facility PPS and Other Outpatient Waivers.** Insofar as necessary for the purposes of testing this Model during the Agreement Term and insofar as the State remains in compliance with the terms of this Agreement, CMS will evaluate a request for a waiver from Inpatient Psychiatric Facility PPS (42 CFR §§ 412.400 et seq.) to better facilitate the integration of behavioral health and physical health in the Model. Such waiver may be requested in accordance with Section 5.a., to extend global or population-based budgets to Inpatient Psychiatric Facilities together with a CRP Track initiated under the CRP pursuant to Section 9.a of this Agreement. Such waiver, if issued, would be set forth in an amendment to this Agreement or in separately issued documentation.