MARYLAND ALL-PAYER MODEL
CHANGE-OF-NAME AGREEMENT

The Maryland Department of Health and the Centers for Medicare & Medicaid Services ("CMS") (hereinafter "the Parties") enter into this agreement as of July 1, 2017.

(a) THE PARTIES AGREE TO THE FOLLOWING FACTS:

(1) CMS and the Department of Health and Mental Hygiene entered into the Maryland All-Payer Model Agreement dated February 11, 2014, as amended (the "Agreement").

(2) The Department of Health and Mental Hygiene changed its name to Maryland Department of Health effective July 1, 2017.

(3) The amendment made by section (b)(1) of this agreement accomplishes the change of name only and all rights and obligations of the Parties under the Agreement are unaffected by this change.

(4) Documentary evidence of this new legal name, authenticated by the appropriate state official, has been filed with CMS.

(b) IN CONSIDERATION OF THESE FACTS, THE PARTIES AGREE THAT—

(1) The Agreement is amended by substituting the name "**Maryland Department of Health**" for the name "**Department of Health and Mental Hygiene**" wherever it appears in the Agreement;

(2) This agreement is effective as of the day and year first above written; and

(3) The signatory for the Maryland Department of Health certifies and warrants that he or she is authorized to enter into this agreement on behalf of the Maryland Department of Health.

CENTERS FOR MEDICARE & MEDICAID SERVICES

By _____

Name of Authorized Signatory A. Berlon

Title Director, Center + Deputy Admin CMS

MARYLAND DEPARTMENT OF HEALTH

By _____

Name of Authorized Signatory Robert R. Neall

Title Secretary

Maryland All-Payer Model Agreement

Second Amendment

This amendment is made to the Maryland All-Payer Model Agreement ("Agreement") dated February 11, 2014 between the Centers for Medicare & Medicaid Services ("CMS"), the Governor of Maryland, the Department of Health and Mental Hygiene now the Maryland Department of Health ("MDH"), and the Health Services Cost Review Commission ("HSCRC") (the Governor of Maryland, MDH, and HSCRC are collectively referred to herein as the "State" or "Maryland").

The purpose of this amendment is to require the State to calculate an adjustment to the Regulated Maryland Hospitals' Medicare payments as described in the attached Appendix 10 ("Medicare Performance Adjustment"). The Medicare Performance Adjustment will support state-wide efforts to reduce the growth in Medicare total cost of care ("TCOC") , facilitate the State's transformation to a TCOC model, and permit the Maryland All-Payer Model ("Model") to qualify as an Advanced APM under the Quality Payment Program. In addition, this amendment makes other changes necessary to permit the Model to qualify as an Advanced APM under the Quality Payment Program, clarifies provisions regarding the performance period and term of the Agreement, and modifies Appendix 9 of the Agreement to reflect changes to the Care Redesign Program that will be implemented through the execution of new Care Redesign Program participation agreements.

The parties therefore amend the Agreement as set forth below.

1. Effective Date. This amendment shall be effective when it is signed by the last party to sign it (as indicated by the date associated with that party's signature).

2. Maryland authority to implement Model. Section 1.c of the Agreement is hereby amended by inserting immediately after the last sentence the following:

   The State represents and warrants that it 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.

3. Performance Period of Model. Section 2 of the Agreement is hereby amended to state:

   Performance Period of Model and Term of Agreement

   a. Performance Period of Model. The performance period shall consist of five performance years, each of 12 months' duration beginning on January 1 ("Performance Year"). The performance period of this Model will begin on January 1, 2014, and will end at midnight on December 31, 2018. CMS or the State may terminate the performance period of this

Agreement up to and including 11:59 PM EST on December 31, 2018 in accordance with Section 14. Unless CMS and the State enter into a separate agreement for a new model to begin upon the completion or termination of the performance period of this Agreement, the State and Regulated Maryland Hospitals shall have two calendar years from the effective date of the completion or termination of the performance period of this Agreement to complete a transition to payment under the national Medicare program, whereupon this Agreement shall terminate automatically. Prior to the beginning of Performance Year 4, Maryland will submit a proposal for a new model, which shall limit, at a minimum, the Medicare per beneficiary total cost of care growth rate, to take effect no later than 11:59 PM EST on December 31, 2018. Approval of this new model proposal shall be in the sole discretion of CMS and shall require a separate agreement executed by CMS and the State.

b. Term of Agreement. The term of the Agreement begins January 1, 2014 and will end December 31, 2020. The parties acknowledge that CMS and the State will implement the Medicare Performance Adjustment (as defined in Appendix 10) through June 30, 2020.

4. Use of Certified EHR Technology. Section 8 of the Agreement is hereby amended by inserting after paragraph (b) the following new paragraph (c) as follows and renumbering the existing paragraphs of section 8 accordingly, including any references thereto:

c. ***Use of Certified EHR Technology (CEHRT).*** *CEHRT means CEHRT as defined in 42 CFR § 414.1305. The HSCRC shall require each Regulated Maryland Hospital to use CEHRT to document and communicate clinical care to their patients or other health care providers in accordance with 42 CFR § 414.1415(a)(1)(i).*

5. Medicare Performance Adjustment. As renumbered pursuant to Section 4 of this amendment, Section 8.d of the Agreement, *Population-based revenue*, is hereby amended by inserting after paragraph (i) the following new paragraph (ii) as follows and renumbering the existing paragraphs of Section 8.d accordingly, including any references thereto:

ii. ***Medicare Performance Adjustment.*** *The State shall calculate a Medicare Performance Adjustment, as defined and calculated in accordance with Appendix 10, for each Regulated Maryland Hospital, which CMS will apply to the Regulated Maryland Hospital's Medicare FFS payments during the Rate Year, as set forth in Appendix 10. The State represents and warrants that the State has, or will have by no later than July 1, 2018, bound by law or by contract all Regulated Maryland Hospitals to accept payment in accordance with this section 8.d.ii and Appendix 10.*

6. Appendix 9. Appendix 9 of the Agreement is hereby amended as follows:

a. Definitions. The following definitions are hereby amended as follows:

"CRP Beneficiary" is hereby amended by striking "that incurs Episodic Costs."

"CRP Performance Period" means the period of time when one or more CRP Tracks is in effect. The first Performance Period began on July 1, 2017 and ended December 31, 2017. The second Performance Period began January 1, 2018 and will end June 30, 2018. The third Performance Period will begin July 1, 2018 and will end on December 31, 2018.

"Downstream Care Partner" is hereby amended by striking "(5) has a written Downstream Care Partner Arrangement with its PGP Care Partner" and inserting in its place "(5) has a Downstream Care Partner Arrangement with its PGP Care Partner".

"Episodic Costs" is hereby struck.

"Geographic Costs" is hereby struck.

"Service Area" is hereby amended by striking "global budget revenue or total budget revenue" and inserting in its place "payment for the CRP Hospital's services".

"TCOC" is hereby struck.

"TCOC Performance" is hereby struck.

b. Incentive Payment Pool. Section 6.a of Appendix 9, is hereby amended to read in its entirety:

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 (as such term is defined in Appendix 10). The Quality Adjustment Score shall be calculated in accordance with Section 3.a of Appendix 10.

c. Total Cost of Care. Section 7 of Appendix 9, is hereby struck in its entirety and the existing sections of Appendix 9 are renumbered accordingly, including any references thereto.

d. New CRP Participation Agreement. Section 2.h of Appendix 9 is hereby amended to read in its entirety as follows:

The HSCRC shall not permit any hospital to implement a CRP Track unless the hospital is a party to a CRP Participation Agreement that is in effect. The parties to this Agreement shall ensure that no CRP Hospital continues to participate in the CRP after June 30, 2018 unless such CRP Hospital has executed a new CRP Participation Agreement between CMS and the State that will govern the hospital's participation in the CRP starting July 1, 2018.

7. Appendix 10. The Agreement is hereby amended to add the attached Appendix 10 immediately after Appendix 9. In the event of any inconsistency between the provisions of

Appendix 10 and the provisions of the Agreement relative to the subject matter of Appendix 10, the provisions of Appendix 10 will prevail.

[SIGNATURE PAGE FOLLOWS]

Each party is signing this amendment on the date stated next to that party's signature. If a party signs this amendment, 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 such signing party signed this amendment.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Date: 6/19/18

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

OFFICE OF THE GOVERNOR OF MARYLAND

Date: 6/14/18

By: _____
Lawrence J. Hogan, Jr.
Governor

HEALTH SERVICES COST REVIEW COMMISSION

Date: 6/8/2018

By: _____
Nelson Sabatini
Chair

MARYLAND DEPARTMENT OF HEALTH

Date: 6/13/18

By: _____
Robert R. Neall
Secretary

Attachment: Appendix 10

Appendix 10: Medicare Performance Adjustment

1. Definitions

The following terms are defined for purposes of this Appendix 10 as set forth below:

"Maximum Performance Threshold" is a variable used in calculating the MPA, which equals 2 percent.

"Maximum Revenue at Risk" is a variable used in calculating the MPA, which is at least 0.5 percent.

"Medicare 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 entitled to benefits under Medicare Part A and enrolled under Medicare Part B but not Medicare Part C (Medicare Advantage) or Part D.

"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 3.b of this Appendix 10.

"Rate Year" means the 12 month period beginning on July 1, 2019 and ending on June 30, 2020.

2. **MPA Proposal.** 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 2.b of this Appendix ("**MPA Proposal**").

    a. The State's MPA Proposal must include the following components:

        i. 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 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% of Medicare FFS Beneficiaries who reside in Maryland.

ii. 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 2018 Performance Year ("**TCOC Performance**") for each Regulated Maryland Hospital.

iii. 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 2.a.i of this Appendix 10.

iv. A proposed methodology to calculate the benchmark total cost of care ("**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.

v. 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 2018 Performance Year using the Medicare Beneficiary Attribution Algorithm proposed by the State in accordance with Section 2.a.i of this Appendix 10.

vi. A proposed methodology to be used in Step 5 of the calculation described in Section 3.a of this Appendix 10 to make adjustments to the results of Step 4 of such calculation based on efficiency or other measures.

vii. 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 7 of this Agreement, at least one of which must satisfy the requirements of 42 C.F.R. § 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 must include the following two measures in its proposed Quality Adjustment Score methodology:

1. The 30-day all-payer case-mix adjusted readmission rate for patients who were hospitalized at an acute care hospital and

experienced an unplanned readmission for any cause to an acute care hospital within 30 days of discharge.

2. The composite result for the Potentially Preventable Conditions (PPCs) that constitute Maryland's Hospital Acquired Condition program.

Notwithstanding the standard for unilateral amendments articulated in Section 13 of the Agreement, CMS may unilaterally amend Appendix 7 or other provisions of this Agreement as necessary for the Model to meet the Advanced APM criterion in 42 CFR § 414.1415(b) and to comply with applicable federal or state laws, rules, and regulations, in which case CMS will provide advance written notice to the State in accordance with Section 13 of the Agreement.

b. **CMS Review**. Within 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 30 days of CMS's request. If CMS does not request further revisions within 30 days of receiving such revisions from the State, those revisions will be deemed to be approved.

3. **Calculation and Application of the MPA**. By May 31, 2019, the State shall calculate the MPA for each Regulated Maryland Hospital for the 2018 Performance Year in accordance with the 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.

a. 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 2018 Performance 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 [TCOC Benchmark – TCOC Performance] / TCOC Benchmark * [Maximum Revenue at Risk / Maximum Performance Threshold], and

2. "B" is (1 + Quality Adjustment Score) when "A" is greater than or equal to zero, and is (1 – 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.

b. **Application of the MPA.** During the Rate Year, CMS will adjust each Medicare FFS payment to a Regulated Maryland Hospital by that Regulated Maryland Hospital's MPA.

4. **Record Retention.** In accordance with Section 12.c of the Agreement, the State shall maintain records regarding all components of the MPA Proposal specified in Section 2 of this Appendix and all components of its calculation of the MPA for each Regulated Maryland Hospital, including the calculation of the Quality Adjustment Score for each Regulated Maryland Hospital.

5. **Survival.** Termination of this Agreement shall not affect the rights and obligations of the parties accrued under this Agreement or this Appendix prior to the effective date of termination or expiration of this Agreement, including obligations regarding submission of reports and other data, record retention under Section 12.c of the Agreement, monitoring and evaluation activities, and cooperation with monitoring and evaluation activities. The rights and duties under Section 8.d.ii of this Agreement and this Appendix 10 shall also survive the expiration or termination of this Agreement and apply thereafter.