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

This States Advancing All-Payer Health Equity Approaches and Development Model State Agreement ("**Agreement**") is entered into by and between the Centers for Medicare & Medicaid Services ("**CMS**") and the Governor of Maryland, the Maryland Department of Health ("**MDH**"), and the Health Services Cost Review Commission ("**HSCRC**") (collectively, "**State**" or "**Maryland**"). The State and CMS are hereinafter collectively referred to as "**the Parties**."

RECITALS

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

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

The Parties therefore agree as follows:

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

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

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

    d. **Implementation Period.**

        i. The Implementation Period begins on January 1, 2026 (the "**Start Date**") and ends at 11:59 PM ET on December 31, 2034, unless the Implementation Period is sooner terminated in accordance with Section 22. The Implementation Period consists of the following 12-month Performance Years ("PY"):
            1. PY 1: January 1, 2026 – December 31, 2026
            2. PY 2: January 1, 2027 – December 31, 2027
            3. PY 3: January 1, 2028 – December 31, 2028
            4. PY 4: January 1, 2029 – December 31, 2029

5. PY 5: January 1, 2030 – December 31, 2030
6. PY 6: January 1, 2031 – December 31, 2031
7. PY 7: January 1, 2032 – December 31, 2032
8. PY 8: January 1, 2033 – December 31, 2033
9. PY 9: January 1, 2034 – December 31, 2034

e. By the end of PY9 (December 31, 2034), CMS will notify the State if, at that time, it has made a decision to (1) expand the Model pursuant to Section 1115A(c) of the Social Security Act, (2) amend this agreement to extend the performance years of the AHEAD model; or (3) announce a new CMS Innovation Center model for which the State may be eligible to participate. The aforementioned deadlines do not preclude CMS from announcing on a later date that it intends to expand the Model pursuant to Section 1115A(c) of the Social Security Act or to implement a new CMS Innovation Center model for which the State may be eligible to participate.

f. If, in accordance with Section 1.e., by December 31, 2034, CMS notifies the State (1) that CMS has not made a decision on whether to expand the Model pursuant to Section 1115A(c), or (2) that CMS does not intend to extend the performance years of the AHEAD model and does not intend to announce a new CMS Innovation Center model for which the State may be eligible to participate, the State may propose a new model test to CMS no later than December 31, 2035. By December 31, 2036, 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, 2040.

g. **Transition Period.** For the State and Participant Hospitals, the Transition Period will consist of up to 60 months beginning upon the expiration or termination of the Implementation Period of the Model. The length of the Transition Period will consist of 60 months if the State is transitioning to FFS Medicare, unless the following occur: (1) the Transition Period is terminated under section 22, (2) the Model is expanded, or (3) a new model test performance period begins prior to the end of the Transition Period.

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

1. If the Model is expanded by CMS, CMS and the State will prepare to implement the expanded Model or new multi-state model during the Transition Period. The State will remain subject to the Medicare FFS TCOC Target described in Section 10.a. until the start date of the model expansion or new multi-state model.
2. If the Model is not expanded and a new model test is not implemented, or if the Transition Period is triggered prior to December 31, 2034 due to termination of the Implementation Period in accordance with Section 22, Participant Hospitals will transition to the national Medicare FFS payment system over the course of the Transition Period and CMS will take all other actions necessary to wind down the Model test.

ii. **Monitoring:** The State will continue its monitoring activities in accordance with Section 19 of the Agreement throughout the Transition Period.

2. Definitions.

a. **"Allowable CRP Interventions"** means the CRP Interventions set forth in a Participant Hospital's CRP Approved Track Implementation Protocol.

b. **"All-Payer" and "all payers"** means Medicare and Maryland Payers.

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

d. "**All-Payer TCOC Growth Target**" means the numerical target, memorialized in either the State's executive order, legislation, or regulation as described in Section 10, which CMS will hold the State accountable for meeting on an annual basis to limit spending across all payers for all residents in the State. The target is inclusive of all expenditures

for Medicare, Medicaid, and commercial insurance, including, but not limited to, employer-sponsored insurance, state employee health plans, and Marketplace plans.

e. "**Annual Progress Report**" means the annual report submitted by the State to CMS in a form and manner specified by CMS, providing updates on the State's performance and activities from the preceding Performance Year, as described in Section 20.

f. **"Care Redesign Program" or "CRP"** means the program established by the Parties pursuant to this Agreement and the Hospital Participation Agreement facilitating financial arrangements under the Model.

g. "**CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology**" means the methodology designed by the State for prospectively setting an annual budget for Participant Hospitals' inpatient and outpatient services based on the projected utilization of those services. This methodology will apply to hospital revenue generated from claims paid by health care purchasers, including Medicare FFS and Maryland Medicaid, which the State requires to reimburse Eligible Hospitals on the basis of rates established by the HSCRC.

h. **"CRP Approved Track Implementation Protocol"** means a CRP Track Implementation Protocol that has been completed by a Participant Hospital and approved by the Parties in accordance with the applicable Hospital Participation Agreement.

i. **"CRP Care Partner"** means a provider or supplier who (1) is enrolled in Medicare; (2) provides items and services to Medicare FFS Beneficiaries residing in the State; (3) satisfies all applicable CRP Care Partner Qualifications; (4) is identified on the CRP Care Partner List; and (5) has a CRP Care Partner Arrangement with a Participant Hospital.

j. **"CRP Care Partner Arrangement"** means a written financial arrangement between the Participant Hospital and a CRP 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.

k. **"CRP Care Partner List"** means the list of CRP Care Partners and CRP Downstream Care Partners approved by CMS.

l. **"CRP Care Partner Requirements"** means the requirements set forth in the applicable CRP Track Implementation Protocol, with which a CRP Care Partner must comply with in order to participate in a CRP Track and receive Incentive Payments, Intervention

Resources, or both and with which a CRP Downstream Care Partner must comply with in order to participate in a CRP Track and receive Downstream Incentive Payments.

m. "**Commercial Payer**" means a third-party payer of covered services, other than Medicare and Medicaid, including any state government, employer, Health Maintenance Organization ("HMO"), Medicare Advantage, or any third-party administrator contracting on behalf of any such entity.

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

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

p. **"CRP Downstream Care Partner Arrangement"** means a written financial arrangement between a CRP Care Partner and a CRP Downstream Care Partner pursuant to which the CRP Downstream Care Partner participates in a CRP Track and receives Downstream Incentive Payments in exchange for performing Allowable CRP Interventions.

q. **"CRP Intervention"** means an activity or process, available under a CRP Track and set forth in the relevant CRP 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, including health equity; (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.

r. **"CRP Monitoring Plan"** means the plan developed by the State in accordance with Section 12 of this Agreement to monitor compliance of Participant Hospitals with CRP requirements, as applicable.

s. **"CRP Report"** means the report the Participant Hospital submits to the Parties, in accordance with the Hospital Participation Agreement.

t. **"CRP Track"** means a care redesign initiative developed by the Parties and implemented by the Participant Hospital with the assistance of CRP Care Partners, as applicable.

u. **"CRP Track Implementation Protocol"** refers to the Track Implementation Template for a CRP Track that CMS has approved and which is to be completed by a Participant Hospital.

v. **"CRP Track Implementation Template"** means the document in which the State sets forth the proposed design and requirements for a CRP Track, including the information described in Section 12.c of this Agreement.

w. **"Care Transformation Organization" or "CTO"** means a legal entity that deploys an Interdisciplinary Care Management Team to: (1) furnish care coordination services to patients; and (2) perform other activities integral to helping each partner primary care practice or FQHC meet applicable care transformation requirements required by an advanced primary care program.

x. "**CTO Arrangement**" means a contractual arrangement between the MDPCP Participant and a CTO pursuant to which the CTO provides care management services to MDPCP Beneficiaries attributed to the MDPCP Participant and performs other CTO Activities that are integral to meeting the MDPCP Practice Site's Care Transformation Requirements.

y. **"Downstream Incentive Payment"** means a monetary payment made by the CRP Care Partner to a CRP Downstream Care Partner for Allowable CRP Interventions performed on a Medicare FFS Beneficiary by the CRP Downstream Care Partner during the Implementation Period and/or Transition Period.

z. "**Eligible Hospital**" means an acute care hospital (including related freestanding medical facilities as defined in Health General Article of the Annotated Code of Maryland, § 19-3A-01), Critical Access Hospital, or Rural Emergency Hospital that provides inpatient and/or outpatient services, is located in the State, meets all eligibility criteria for participation in the AHEAD model, and for which payments are regulated by the State for all payers.

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

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

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

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

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

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

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

hh. **"Hospital Global Budget"** means the method by which a Participant Hospital receives a predetermined, fixed annual budget through the application of the CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology for all payers.

ii. "**Hospital Health Equity Plan**" means the health equity plan developed by a Participant Hospital in accordance with the requirements of the Participant Hospital's Hospital

Participation Agreement and reviewed by the Model Governance Structure or other State-selected governing body.

jj. "**Hospital Participation Agreement**" means the participation agreement entered into between the State, CMS, and a Participant Hospital. For Maryland hospitals, this agreement is separate from, and in addition to, the Global Budget Revenue (GBR) agreement between a Participant Hospital and the State.

kk. "**Implementation Period**" means the period beginning on January 1, 2026, and ending on December 31, 2034, unless the Implementation Period is sooner terminated in accordance with Section 22, in which case the Implementation Period concludes on the effective date of such termination.

ll. **"Incentive Payment"** means a monetary payment made by the Participant Hospital to a CRP Care Partner for Allowable CRP Interventions performed on a Medicare FFS Beneficiary by the CRP Care Partner during the Implementation Period, and the Transition Period.

mm. **"Incentive Payment Methodology"** has the meaning set forth in Section 12 of this Agreement.

nn. **"Incentive Payment Pool"** means the aggregate amount of Incentive Payments, as determined by the State in accordance with Section 12 of this Agreement that a Participant may pay its CRP Care Partners in a CRP Track for the applicable Performance Year.

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

pp. **"Intervention Resource Allocation"** means a monetary amount, as determined by the State in accordance with Section 12 of this Agreement that the Participant Hospital may use to fund Allowable Intervention Resources during the Implementation Period, and Transition Period.

qq. "**Local Tribal Community**" means the Indian Health Service, Tribes, and Tribal organizations as defined in section 4 of the Indian Health Care Improvement Act, and

urban Indian organizations operating under Title V of the Indian Health Care Improvement Act.

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

ss. **"Maryland Primary Care Program" or "MDPCP"** means the Medicare advanced primary care program initially developed under the Maryland Total Cost of Care Model and which will continue to be implemented under AHEAD pursuant to the terms of this Agreement and the MDPCP AHEAD Participation Agreements.

tt. "**MDPCP Beneficiary**" means a beneficiary who is attributed to the MDPCP Participant by CMS.

uu. "**MDPCP Participant**" means any primary care practice or FQHC that has entered into an MDPCP AHEAD Participation Agreement with CMS.

vv. "**MDPCP Partner CTO**" means an organization that has entered into a CTO Arrangement with a MDPCP Participant to provide support and resources to that Participant.

ww. **"MDPCP Track 2"** means the track of MDPCP in which a primary care practice or FQHC that meets the eligibility criteria discussed in the applicable MDPCP AHEAD Participation Agreement may participate.

xx. **"MDPCP AHEAD Participation Agreement"** means the participation agreement entered into between CMS and a MDPCP AHEAD Participant or MDPCP Partner CTO.

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

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

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

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

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

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

eee. **"Medicare Performance Adjustment" or "MPA"** means the percentage by which a Participant Hospital's Medicare FFS payments will be adjusted by CMS in accordance with Section 11.e.

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

ggg. **"Outcomes-Based Credits"** are credits that reduce the calculated Medicare FFS PBPY expenditures for a given Performance Year as approved and verified by CMS in accordance with Section 10.a. of this Agreement.

hhh. **"Primary Care AHEAD Participation Agreement"** means the participation agreement entered into between CMS, and a Participant Primary Care Practice that is eligible to receive an EPCP.

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

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

kkk. **"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.

lll. **"PAU Savings"** means the Medicare cost savings that the Participant Hospital is deemed to have achieved for a CRP Track through the reduction of PAU and other savings that the Participant Hospital achieved as a result of the reduced PAU, as determined by the State in accordance with Section 12 of this Agreement.

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

nnn. **"PGP"** stands for "physician group practice."

ooo. **"PGP Member"** or **"Member of the PGP"** means a physician or non-physician practitioner 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.

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

qqq. **"Primary Care AHEAD**" means the CMS-designed primary care program described in Section 13 and does not mean MDPCP described in Section 14 or the Medicaid Advanced PCP described in Section 13.

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

sss. **"Program Integrity Screening"** means a review of an individual's or entity's program integrity history and current status, which may include, but is not limited to, a review of the individual's or entity's eligibility, history of exclusion, investigations, probations, actions or corrective action plans or other sanctions imposed with respect to participation in Medicare, Medicaid, or the Children's Health Insurance Program (CHIP), history of failure to pay Medicare debts in a timely manner, current or prior law enforcement investigations or administrative actions, affiliations with individuals or entities that have a history of program integrity issues, and other information pertaining to the trustworthiness of the individual or entity.

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

methodology will apply to hospital revenue generated from claims paid by all payers, including Medicare FFS and Maryland Medicaid, which the State requires to reimburse Eligible Hospitals on the basis of rates established by the HSCRC.

uuu. **"Rate Year**" means the period from July of one calendar year through June of the next.

vvv. "**Regulated Revenue**" means the full subset of revenue earned by Eligible Hospitals for which the State has the legal authority to set payment rates.

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

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

yyy. "**SPCS**" means select primary care services identified by Healthcare Common Procedure Coding System (HCPCS) codes, as modified from time to time, in the MDPCP AHEAD Payment Methodologies Paper.

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

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

bbbb. "**Transition Period**" means the period of up to 60 months, beginning upon the completion or termination of the Implementation Period of the Model.

cccc. "**Underserved Communities**" as defined by Executive Order 13985, means populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life such as Black, Latino, and Indigenous and Native American persons,

Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

3. CMS Legal Authority.

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

b. **Waiver Authority.** Under Section 1115A(d)(1) of the Act, the Secretary may waive such requirements of Titles XI and XVIII and of Sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and 1934 (other than subsections (b)(1)(A) and (c)(5) of such section) of the Act as may be necessary solely for purposes of carrying out Section 1115A with respect to testing models described in Section 1115A(b). CMS may withdraw or modify any waivers issued by CMS if the State does not comply with the terms and conditions set forth in this Agreement or with the terms and conditions of waivers as set forth in this Agreement or in separately issued documentation.

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

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

e. **Model Participation Agreements.** CMS and the State will enter into the following Participation Agreements:

    a. CMS and the State will enter into Hospital Participation Agreements with Participant Hospitals.
    b. CMS will enter into Primary Care AHEAD Participation Agreements with Participant Primary Care Practices.
    c. CMS will enter into MDPCP AHEAD Participation Agreements with MDPCP Participants.
    d. CMS and the State will enter into MDPCP AHEAD Participation Agreements with MDPCP Partner CTOs.

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 Eligible 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

Eligible 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 Eligible 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), Participant Hospitals, and all Maryland Payers not subject to the federal Employee Retirement Income Security Act (ERISA) of 1974 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.

d. **Maryland Medicaid Authority.**

   i. The State warrants that the MDH has designated authority as Maryland's State Medicaid Agency (SMA).

   ii. The State also represents and warrants that the MDH has the authority to administer Maryland's Medicaid program under Title 15 of the Health-General Article, Annotated Code of Maryland.

5. Waivers and Safe Harbor Authority.

a. **Payment Waivers.**

   i. Subject to the provisions of this Agreement, CMS will waive the requirements of the Act as listed in Appendix E of this Agreement solely for purposes of testing the Model. All other Medicare coverage and payment requirements are applicable, if not otherwise waived under federal law.

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

b. **Fraud and Abuse Waivers.** Financial arrangements between and among providers and suppliers must comply with all applicable laws and regulations, except as may be explicitly provided in a waiver issued specifically for AHEAD pursuant to Section 1115A(d)(1) of the Act. The Secretary may consider issuing one or more waivers of certain fraud and abuse provisions in Sections 1128A, 1128B, and 1877 of the Act (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. **Federal Anti-kickback Statute Safe Harbor.** CMS may determine that the Federal anti-kickback statute safe harbor for CMS-sponsored model arrangements (42 C.F.R. § 1001.952(ii)(1)) and CMS-sponsored model patient incentives (42 C.F.R. § 1001.952(ii)(2)) is available to protect remuneration exchanged pursuant to certain financial arrangements or patient incentives permitted under applicable AHEAD Participation Agreements, provided that such arrangements and incentives comply with the requirements of the safe harbor and the requirements to be set forth in the applicable participation agreement. No such determination is being issued in this document. Such determination, if any, would be set forth in documentation separately issued by CMS. Once CMS has made such a determination, the Secretary may modify or revoke the availability of the federal anti-kickback statute safe harbor at any time and for any reason without the consent of the State.

6. State's Participation in other Medicare Programs, Models, or Demonstrations.

The State may simultaneously participate in AHEAD and other Medicare programs, models, or demonstrations in existence on the Effective Date.

7. Cooperative Agreement.

a. The Parties acknowledge that prior to the Effective Date of this Agreement, the State entered into a Cooperative Agreement with CMS. Through the Cooperative Agreement,

CMS will make funding available to the State to support the State's participation in the Model.

b. The State's ability to receive this funding is subject to the State's ongoing compliance with the terms of this Agreement, the terms and conditions of the Cooperative Agreement award, and any other terms and conditions imposed by CMS.

8. General Model Participation Requirements.

a. **Medicare FFS Beneficiary Minimum.**

If CMS determines, at any time during the Implementation Period, that the number of Medicare FFS Beneficiaries who reside within the State falls below 10,000, CMS will consider such determination to be a Triggering Event, as defined in Section 22.b.

b. **Hospital Participation Requirements.**

The State must ensure that 90 percent of all Regulated Revenue for Maryland residents is paid according to the CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology as described in Section 11.

c. **Commercial Payer Requirements.**

i. The State will continue to set Hospital Global Budgets for all Commercial Payers pursuant to its authority under Md. Code Ann. Health-Gen. § 19-201 et seq. and NY State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995).

ii. The State must hold Commercial Payers accountable for TCOC growth, based on the Statewide Accountability Targets, using available legislative or regulatory authority. CMS acknowledges that some State legislative and regulatory tools may be limited by preemption of state regulation of employer-sponsored health insurance plans under ERISA (see 29 US Code § 1144) and will consider this when evaluating the state's performance.

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

The State will continue to set Hospital Global Budgets for Medicaid pursuant to its authority under Md. Code Ann. Health-Gen. § 19-201 et seq.

e. Medicaid Advanced PCP.

i. The Parties acknowledge that during the Pre-Implementation Period, the State implemented a Medicaid Advanced PCP approved by CMS.

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

9. Model Governance Structure.

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

b. **Function.** The Model Governance Structure or another State-selected governing body must provide input to the State regarding the following Model implementation activities:
   i. The selection of, and changes to, the Statewide Quality and Equity Targets, as described in Section 10;
   ii. The development of the Statewide Health Equity Plan and the production of the Annual Progress Report documenting the State's progress in implementing the Statewide Health Equity Plan, as described in Section 20.c.;
   iii. The review of the Hospital Health Equity Plan described in Section 20.d.;
   iv. Use of State planning funds on investments and other activities designed to meet the Model's quality and cost growth objectives described in Section 10; and
   v. Cooperative Agreement funding.

c. The State must maintain the Model Governance Structure or State-selected governing body, as applicable, throughout the Implementation Period of the Model.

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

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

10. Statewide Accountability Targets.

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

i. No fewer than 30 days prior to the start of a PY, CMS will calculate the Medicare FFS TCOC Target for that PY, based on the following Savings Component schedule and as outlined in Appendix A:

PY1	0.128%
PY2	0.128%
PY3	0.128%
PY4	0.128%
PY5	0.128%
PY6	0.128%
PY7	0.128%
PY8	0.128%
PY9	0.128%

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

iii. **Outcomes-Based Credits.** The State may receive credit for savings generated by addressing certain population health priorities as described in this Section 10 ("**Outcomes-Based Credit**"). Any such Outcomes-Based Credits generated in accordance with this section will be reflected in the calculation of the State Medicare FFS PBPY expenditures for the applicable PY consistent with the methodology described in Appendix A. The population health priorities that Outcomes-Based Credits may address and the methodology of calculating and applying such credit shall be developed as follows:

1. At any time following the Effective Date of the Agreement, the State may propose to CMS methodologies for assessing the State's performance on an identified population health priority, which may include, but are not limited to priorities that correspond to one or more Statewide Quality and Equity Targets in accordance with Section 10.e. or Statewide Population Health Targets in accordance with Section 10.f.

a. For each proposed population health priority, the State must submit the following information:
    i. Specifications for appropriate population health measures and applicable performance targets. Such specifications shall be in alignment with the Statewide Quality and Equity Targets or Statewide Population Health Targets, as applicable;
    ii. 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
    iii. An estimate of the savings to Medicare that could be expected due to an improvement by the State on each measure and target.
b. 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.

2. On or before December 31 of each Performance Year from PY1 through PY9, the State may submit to CMS a memorandum for each previously-approved Outcome-Based Credit detailing the State's assessment of the amount to be applied to the Medicare FFS TCOC Target for the Performance Year in which the memorandum is submitted.
    a. The State's memorandum 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 priority approved by CMS in accordance with this section:
        i. The State's performance against the applicable CMS-approved Outcome-Based Credit performance target; and
        ii. An estimate of the savings to Medicare due to the State's performance compared with that Outcome-Based Credit

performance target.

b. If CMS does not reject the State's amount in the memorandum 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 amount is deemed approved.

For purposes of this Model, the Diabetes Outcomes-Based Credit developed and approved under the Maryland Total Cost of Care (TCOC) Model shall be considered a previously-approved Outcomes-Based Credit. Any and all associated measures, targets, and methodologies related to the Diabetes Outcomes-Based Credit are incorporated herein by reference and will form a part of this Agreement as if set forth herein in their entirety. The parties agree to amend the approved methodology as may be necessary to ensure the Diabetes Outcomes-Based Credit is properly integrated into this Model. For clarity, the documents incorporated by reference are as follows: "Diabetes Outcomes-Based Credit Methodology under the Maryland Total Cost of Care Model" dated January 17, 2019, and revised May 2, 2019, and "Outcome-Based Credit Methodology on Diabetes Incidence" approval letter dated July 17, 2019.

iv. **Failure to Meet Targets.** If the State exceeds the Medicare FFS TCOC Target in any two PYs within a period of three consecutive PYs, CMS will issue a Warning Notice and may issue an Enforcement Action Notice, in a form and manner as described in Section 22.

v. **Performing Better than Targets.** If the State limits Medicare FFS PBPY expenditures for a PY to $5 per beneficiary per month (PBPM) less than the Medicare FFS TCOC Target for that PY, CMS may, at its sole discretion, offer the State increased Medicare primary care payments, as described in Section 13.c., for a subsequent PY. CMS, in a form and manner to be determined by CMS, will provide the State notice of CMS' offer to increase the EPCP amount, the process to accept the offer, and the requirements the State must follow if the State accepts increased

Medicare primary care payments, as described in Section 13.c., including, but not limited to, signing an amendment to this Agreement.

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

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

ii. No later than ninety (90) days prior to the start of PY2, the State must provide to CMS the All-Payer TCOC Growth Target for each of PYs 2 through 5, at a minimum. If the State's executive order, legislation, or regulation does not establish the All-Payer TCOC Growth Targets for PYs 6 through 9, the State must submit to CMS the All-Payer TCOC Growth Target for each of these PYs no later than ninety (90) days prior to the start of the applicable PY.

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

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

v. **Failure to Meet Targets.** If the State exceeds the All-Payer TCOC Growth Target for any two Performance Years within a period of three consecutive Performance Years, CMS will issue a Warning Notice and may issue an Enforcement Action Notice in a form and manner as described in Section 22.

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

i. The State must meet or exceed its annual Medicare FFS Primary Care Investment Target for each Performance Year, as described in Appendix B.

ii. **Calculation Methodology.** CMS will calculate the State's performance on the Medicare FFS Primary Care Investment Target using the methodology described in Appendix B.

iii. **Failure to Meet Targets.** If the State does not meet the Medicare FFS Primary Care Investment Target in any two Performance Years within a period of three consecutive Performance Years, CMS will issue a Warning Notice and may issue an Enforcement Action Notice, in a form and manner as described in Section 22.

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

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

ii. No later than ninety (90) days prior to the start of PY2, the State must provide to CMS the All-Payer Primary Care Investment Target for each of PYs 2 through 5, at minimum. If the State's executive order, legislation, or regulation does not establish the All-Payer Primary Care Investment Targets for PYs 6 through 9, the State must submit to CMS the All-Payer Primary Care Investment Target for each of these PYs no later than ninety (90) days prior to the start of the applicable PY.

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

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

v. **Failure to Meet Targets.** If the State does not meet the All-Payer Primary Care Investment Target in any two Performance Years within a period of three consecutive Performance Years, CMS will issue a Warning Notice and may issue an Enforcement Action Notice, in a form and manner as described in Section 22.

e. **Statewide Quality and Equity Targets**

i. The State shall, with CMS' approval, select, at a minimum, five (5) statewide core and one (1) optional measure described in Appendix I, and set biannual interim and final quality and equity targets for each selected measure (collectively, the "**Statewide Quality and Equity Targets**"). The State shall select goals that exceed the results achieved under the Maryland Total Cost of Care Model.

ii. On or before May 1, 2025, the State may propose to CMS one or more measures that are not included in Table 1 or Table 2 of Appendix I as one of the State's selected measures. Each proposed measure that is intended to replace a core measure must be in the same domain as the measure that it is intended to replace. Each proposed measure that is intended to replace an optional measure must either be in one of the

domains provided in Table 2 of Appendix I for optional measures, or the State may propose another domain aligned with the Statewide HEP. When proposing the measure to CMS, the State must provide a rationale to CMS that explains why the proposed measure better serves the goals of the Model compared to the measure or measures in Table 1 or Table 2 of Appendix I in the same domain. CMS will either approve or reject the proposed measure within 30 days of receipt of the State's proposal.

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

iv. The State must measure and report to CMS on the State's performance on the interim and final Statewide Quality and Equity Targets in the Statewide Health Equity Plan as part of its Annual Progress Report for each PY of the Model, as outlined in Section 20.

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

1. In the State's request, the State must address one or more of the following factors:
    i. Alignment of the proposed measure with AHEAD quality goals and required quality domains in the Statewide HEP;
    ii. Any variance from expected performance on the previously selected statewide core or optional measure described in Appendix I that prevents ascertainment of meaningful improvements;
    iii. The availability of a more broadly applicable (across settings, populations, or conditions) measure for the State health needs identified in the Statewide HEP; or

iv. The availability of another measure that the State believes is more aligned with the State health needs identified in the Statewide HEP.

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

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

vii. **Failure to Meet Targets.** If the State does not meet its Statewide Quality and Equity Targets for PY 2, 4, 6, or 8, and/or the State performance on the selected statewide core and optional measures declines from one PY to another, CMS will issue a Warning Notice and may issue an Enforcement Action Notice, in a form and manner as described in Section 22.

f. **Statewide Population Health Targets.** The State shall, with CMS' approval, identify one or more measures to assess the Model's impact on population health, and set biannual interim and final performance targets for each selected measure (collectively, the "**Statewide Population Health Targets**").

i. No later than July 1, 2025, the Parties will document the targets in separately issued documentation entitled "**Selected Statewide Population Health Targets for the AHEAD Model.**"

ii. **Dedicated Fund for Population Health.** For the purpose of meeting the Statewide Population Health Targets, the State will develop a dedicated fund ("**Population Health Trust**") comprised of public and private sources to support statewide population health improvement initiatives in alignment with both the Statewide Health Equity Plan and the State Health Improvement Plan (SHIP). This work builds on the Statewide Integrated Health Improvement Strategy (SIHIS) established under the Total Cost of Care Model and is informed by the local "wellness funds" developed in support of the Accountable Communities for Health model. The fund will be used to support activities designed to achieve at least one of the following functions:

a. Reduce rates of common preventable health conditions;

b. Increase healthy habits;
c. Address health-related social needs (HRSN);
d. Reduce or eliminate health disparities; or
e. Build evidence of effective prevention programs

iii. **Failure to Meet Targets.** If the State does not meet its Statewide Population Health Targets for PY 2, 4, 6, or 8, CMS will issue a Warning Notice and may issue an Enforcement Action Notice, in a form and manner as described in Section 22.

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

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

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

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

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

h. **All-Payer Revenue Limit.**

i. For each PY, the State must limit the annual growth in revenue to Participant Hospitals from all payers to less than or equal 3.58 percent multiplied by (1 + the Population Growth Percentage) for that Performance Year, as calculated by the State following the methodology in Appendix F, unless replaced by an alternative proposed by the State and approved by CMS.

ii. By no later than May 1 of each PY, beginning in PY2, the State will calculate the All-Payer Revenue Limit for the prior PY, as defined and calculated in accordance with Appendix F of this Agreement.

iii. By no later than May 1 of each PY, for PY2 through PY9, the State will compare the actual Regulated Gross Patient Service Revenue (defined in Appendix F) for the prior PY to the All-Payer Revenue Limit (defined in Appendix F) for that PY, each defined and calculated in accordance with the specifications in Appendix F of this Agreement.

iv. The State shall provide the results of the calculations performed pursuant to this Section 10.h. and Appendix F 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 to CMS in a manner consistent with Section III of Appendix F of this Agreement.

v. The State may request to update the Growth Limit (defined in Appendix F) used to calculate the All-Payer Revenue Limit, as specified in Appendix F 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.

vi. Any changes to the specifications for calculating the All-Payer Revenue Limit requested by the State must be approved by CMS at CMS' sole discretion.

11. Hospital Global Budget Methodology.

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

i. The Parties acknowledge that this Model, including payment under the CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology, is predicated on Health General Article of the Annotated Code of Maryland, § 19-201 et seq., and the State's maintenance of an all-payer rate-setting system whereby:

1. The total costs of all Eligible Hospitals' services are reasonable (Health General Article of the Annotated Code of Maryland, § 19-219);
2. The aggregate rates to be charged established by the HSCRC for each Eligible Hospital are related reasonably to the Eligible Hospital's aggregate costs (Health General Article of the Annotated Code of Maryland, § 19-219);
3. Rates are set equitably among all purchasers of hospital services, without undue discrimination or preference (Health General Article of the Annotated Code of Maryland, § 19-219);
4. The HSCRC may review and approve or disapprove the reasonableness of any rate or amount of revenue that a Eligible Hospital sets or requests (Health General Article of the Annotated Code of Maryland, § 19-219); and
5. The State shall require all Eligible Hospitals to submit claims to Medicare FFS using the charge rates established by the HSCRC pursuant to Health General Article of the Annotated Code of Maryland, § 19-201 et seq.

b. **General**

i. The Parties acknowledged that, prior to the Effective Date of this Agreement, the State submitted its Proposed State-Designed All-Payer Hospital Global Budget Methodology to CMS and that CMS approved that methodology for use in PY1 and subsequent PYs.

ii. The State must calculate Hospital Global Budgets for all payers for each PY for each Participant Hospital using the CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology, subject to the requirements of this Section 11 and the applicable terms of this Agreement.

iii. The State will establish rates to be charged for each Participant Hospital to effectuate the CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology.

c. **Payment of Claims.** Consistent with the CMS-Approved State-Designed Hospital Global Budget Methodology, CMS will pay each Participant Hospital through the applicable Medicare Administrative Contractor(s) ("**MAC**") on the basis of the rates to be charged included on the Medicare FFS claims the Participant Hospital submits to the MAC, less the Public Payer Differential described in Section 11.d., and subject to the Medicare Performance Adjustment described in Section 11.e. The Public Payer

Differential will be applied prior to subtracting any applicable deductible or coinsurance amount, and prior to any applicable Medicare secondary payment.

d. **Public Payer Differential.** Prior to the start of PY1, the State shall provide a percentage difference between the rate established by the State for a Participant Hospital for a given charge, in accordance with this Section 11.d, and the lesser rate to be paid by public payers (Medicare including Medicare Advantage plans, Medicaid including Medicaid Managed Care Organizations, and CHIP) to a Participant 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 Agreement.

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

      1. To enable the State to meet the Medicare FFS TCOC Target for the subsequent PYs, provided that Regulated Gross Patient Service Revenue for the current PY is less than the All-Payer Revenue Limit calculated by the State in accordance with Section 10 and Appendix F of this Agreement for that PY; or
      2. To effectuate changes in Participant Hospital overhead allocations or other factors used in Maryland's rate-setting system that may be necessary to adjust, recalibrate, or modernize Maryland's rate-setting structure while avoiding shifting costs.

   ii. The State shall submit a request to change the Public Payer Differential no fewer than 120 days before the first day of the PY in which the modified Public Payer Differential would take effect, or by such other deadline specified by CMS.

   iii. CMS will make reasonable efforts to approve or reject the State's request in writing within 60 days of receipt.

e. **Medicare Performance Adjustment ("MPA").** After each PY during the Implementation Period as well as the calendar year immediately preceding PY1 of this Agreement, the State shall calculate an MPA for each Participant Hospital in accordance with this Section 11.e., which CMS will apply to Medicare FFS payments to Participant

Hospitals in accordance with the CMS-Approved Hospital Global Budget Methodology during the subsequent PY.

i. **MPA Proposal.** For each PY during the Implementation Period, 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 ("MPA Proposal"). The State's MPA Proposal must include the following components:

   1. A proposed algorithm for attributing Medicare FFS Beneficiaries to Participant Hospitals for the purpose of calculating the MPA for each Participant 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 Participant Hospital, or the Participant Hospital where the Medicare FFS Beneficiary receives the plurality of hospital services), and must result in the attribution to one or more Participant Hospitals of at least 95 percent of Medicare FFS Beneficiaries who are enrolled in both Part A and Part B and reside in the State for purposes of inclusion in the MPA calculation for those Participant Hospitals. The State may propose and CMS may consider an MPA attribution algorithm that does not result in the attribution to one or more Participant Hospitals of at least 95 percent of Medicare FFS Beneficiaries who are enrolled in both Part A and Part B and reside in the State but does result in attribution to Participant Hospitals of 99% of costs for Medicare FFS Beneficiaries who are enrolled in both Part A and Part B and reside in the State.
   2. The categories of Medicare FFS costs, excluding certain categories proposed for exclusion by the State, to be attributed to each Participant 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 PY ("TCOC Performance") for each Participant Hospital.

3. A proposed methodology to calculate the TCOC Baseline for each Participant Hospital, based on the Attributed Medicare Costs for the Medicare FFS Beneficiaries attributed to the Participant Hospital for the baseline period using the Medicare Beneficiary Attribution Algorithm proposed by the State.
4. A proposed methodology to calculate a benchmark TCOC ("TCOC Benchmark") for each Participant Hospital. The State's proposed TCOC Benchmark methodology must include a proposed trend factor—to be applied to the TCOC Baseline calculated for each Participant Hospital in order to calculate the TCOC Benchmark.
5. A proposed methodology to calculate the TCOC Performance for each Participant Hospital based on the Attributed Medicare Costs for the Medicare FFS Beneficiaries attributed to the Participant Hospital for the relevant PY using the Medicare Beneficiary Attribution Algorithm proposed by the State.
6. A proposed methodology to be used in Step 5 of the calculation described in Section 11.e.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 Participant Hospital ("Quality Adjustment Score"). The State's proposed Quality Adjustment Score methodology must utilize a subset of the quality measures included in the State's hospital quality and value-based payment programs, 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).
    i. To meet these requirements, and align with the State's hospital quality and value-based payment programs, the State's proposed Quality Adjustment Score methodology must include the following three measures in its proposed Quality Adjustment Score methodology, at a minimum, unless CMS has approved different measures under Section 11.e.i.7.ii:
        1. 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;

2. The composite result for Maryland's Hospital Acquired Condition program; and
3. The Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs).

ii. The State may propose an alternative measure or measures to one or more of the measures listed in Section 11.e.i.7.i as long as the State's proposed Quality Adjustment Score methodology utilizes a subset of the quality measures included in the State's hospital quality and value-based payment programs, 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). If the State proposes an alternative measure, the State must provide a rationale for the change in the measure.

8. A proposal for the maximum share of Medicare FFS payments made to each Participant Hospital that can be lost or gained as a result of the application of the MPA ("Maximum Revenue at Risk"). For PY1 and each subsequent PY, the State's proposal for the Maximum Revenue at Risk must be at least 2.0 percent.
9. A proposal for the threshold percentage between the Attributed Medicare Costs for a Participant Hospital and TCOC Benchmark for that Participant Hospital at which the Maximum Revenue at Risk is triggered for that Participant Hospital ("Maximum Performance Threshold").

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 of the MPA.** By May 31 of each PY, beginning in PY1, the State shall calculate the MPA for each Participant Hospital for the prior calendar 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 Participant Hospital according to the following steps:

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

   Step 2: Calculate the Participant Hospital's TCOC Performance during the prior calendar year using the CMS-approved TCOC Performance methodology.

   Step 3: Calculate the Quality Adjustment Score for the Participant 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 Participant 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 Participant Hospital is equal to the Maximum Revenue at Risk.

   "A" is the [TCOC Benchmark – TCOC Performance] / TCOC Benchmark * [Maximum Revenue at Risk / Maximum Performance Threshold], and

   "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 Participant 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.

f. **Application of the MPA.** During the Rate Year that begins immediately following the Performance Year (or, for application to PY 1, following the calendar year immediately preceding PY1) for which the MPA is calculated by the State in accordance with this

Section 11.f, CMS will adjust each Medicare FFS payment to a Participant Hospital by that Participant Hospital's MPA in accordance with the CMS-Approved State-Designed Medicare FFS Hospital Global Budget.

g. **CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology: Requirements.**

i. The State shall calculate Hospital Global Budgets for each PY for Participant Hospitals using the CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology, subject to requirements of this Agreement.

ii. The State must ensure that 90 percent of all Regulated Revenue for Maryland residents is paid according to the CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology and that such payments calculated under the CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology are subject to adjustments based on the hospital quality and value-based payment programs developed and administered by the State in accordance with Section 11.h.

iii. By no later than May 1 of each PY, beginning in PY2, the State must report to CMS the percentage of all Regulated Revenue for Maryland residents paid under the CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology during the previous Performance Year.

1. This percentage must be calculated by dividing the aggregate amount of Regulated Revenue for Maryland residents paid according to a CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology during the previous Performance Year by the aggregate amount of all Regulated Revenue for Maryland residents during the previous Performance Year.

iv. **State Modifications.** If the State wishes to adopt a new payment methodology for Participant Hospitals, including, but not limited to, a new Hospital Global Budget policy, or to modify which Regulated Revenue is paid under the CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology, as described in this Section 11.g., the State shall provide advance written notice to CMS regarding the proposed new payment methodology.

1. Upon notification, if after consultation with the State, CMS believes the change to be substantive, CMS may request, within fifteen 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.
2. CMS will make reasonable efforts to approve or reject the State's proposals within 180 days of receipt. CMS' review and approval or disapproval of this methodology shall be limited to whether the new payment methodology is operationally feasible, consistent with the calculation methodology requirements for Hospital Global Budgets outlined in Appendix C, and designed to prevent the state from exceeding the Medicare FFS TCOC Target in any two PYs within a period of three consecutive PYs.

h. **CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology: Hospital Quality and Value-Based Programs.**

i. The State will develop and administer hospital quality and value-based payment programs in accordance with the requirements of this Agreement. The State hospital quality and value-based payment programs will include all-payer measures. In the limited cases when all-payer measures are not feasible, the State may include Medicare-specific measures. The State hospital quality and value-based payment programs must include a performance measure designed to increase health equity.

ii. The State must use the results of the State's hospital quality and value-based payment programs to adjust the payments calculated under the Hospital Global Budgets for each Participant Hospital, in accordance with the CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology.

iii. The State's hospital quality and value-based payment programs 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:

1. CMS recognizes that the State may utilize efficiency, performance, and outcome measures not utilized in the programs listed in Section 11.h.,

but that tie to the Model's goals of alignment across the delivery system and reductions in unnecessary and potentially avoidable utilization.

2. 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 shall develop and utilize health equity measures as part of its portfolio of hospital quality and value-based payment measures.

iv. The State's hospital quality and value-based payment programs described in this Section 11.h. 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.

v. **Hospital Quality and Value-Based Programs Reports: State Requirements.** The State shall submit to CMS, in a form and manner and by a date specified by CMS:

1. 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).
2. An annual report documenting any changes in the State's hospital quality and value-based payment programs as compared to the prior PY, the all-payer performance against the State's measures and targets during the PY, the linkage between the measures and targets and the payments under the Hospital Global Budget, and any savings achieved as a result of the State's hospital quality and value-based payment programs during the PY. 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.

vi. **Hospital Quality and Value-Based Programs Reports: CMS Requirements**.

1. By no later than May 1 of each Performance Year, beginning in PY2, CMS will calculate and provide the State, with the readmissions rates

for the previous Performance Year. Such rates will be provided for each Participant Hospital as well as for hospitals nationally. These calculations will be based on data for the prior PY.

2. By no later than June 1 of each Performance Year, beginning in PY2, CMS will provide to the State performance measures for Participant Hospitals as if they were included in CMS's Hospital Value-Based Purchasing program and Hospital Acquired Conditions Reduction program for the prior PY.
3. By no later than May 1 of PY1, CMS will calculate and provide the State with the readmissions rates for the previous Calendar Year. Such rates will be provided for each Participant Hospital as well as for hospitals nationally. These calculations will be based on data for the prior CY.

vii. **CMS Quality Program Waiver Determination.**

1. CMS will assess whether the State has demonstrated in the report submitted to CMS pursuant to this Section 11.h. 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.
2. Within 60 days of receiving the report under Section 11.h.v.2., CMS will assess whether the State has met the requirements of Section 11.h.i-iv. and provide or deny a waiver of Sections 1886(o), 1886(p) and 1886(q) of the Act to the State.

viii. **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 Participant Hospitals under the Hospital Inpatient Quality Reporting (IQR) Program and Hospital Outpatient Quality Reporting (OQR) Programs, as described in this Section 11.h., is included in national Medicare measures and published by CMS in an accurate and appropriate manner.

CMS will include data for Participant Hospitals in the Clinical Data Abstraction Center for auditing purposes.

1. Participant 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 Care Compare website and for the Overall Hospital Quality Star Rating).

2. Participant 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 Care Compare website and for the Overall Hospital Quality Star Rating).

3. Participant 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 Care Compare website and for the Overall Hospital Quality Star Rating).

ix. **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 11.h, together with the MPA applied in accordance with Section 11.e 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 Performance 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 include in the report under 11.h.v.2. 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' 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.
3. CMS will compare the percentages of revenue at risk to determine whether the State has satisfied the Revenue at Risk Standard.
4. The State may submit to CMS new proposed quality and value-based payment for inclusion in the Regulated Revenue at risk. CMS shall review and approve or deny such requests based on alignment with the goals of the Model.

12. Care Redesign Program.

a. The State and CMS shall administer the CRP in accordance with the terms of this Agreement and any applicable Hospital Participation Agreement during the Implementation Period.

b. The CRP under this Model is designed to be a continuation of the CRP implemented under the Maryland Total Cost of Care Model. To the extent CMS determines that the CRP under this Model may materially deviate from the CRP under the Maryland Total Cost of Care Model, CMS may, in its discretion and upon written notice, unilaterally amend this Agreement to cure any such deviations under Section 12.

c. The CRP Tracks, developed and implemented under the Maryland Total Cost of Care Model, specifically the Episode Care Improvement Program (ECIP) and Episode Quality Improvement Program (EQIP), shall be considered approved CRP Tracks and shall survive upon the termination of the Maryland Total Cost of Care Model. Any and all key documents and information related to these CRP Tracks are incorporated herein by reference and will form a part of this Agreement as if set forth herein in their entirety.

The parties agree to amend any such key documents as may be necessary to ensure the CRP Tracks are properly integrated into this Model.

d. **CRP Track Proposals and Amendments**

i. By the deadlines specified in the CRP Calendar (as defined below), the State shall submit to CMS a Track Implementation Template for each new CRP Track that the State wishes to implement, in a form and manner determined by CMS. The State shall promptly submit to CMS any additional information that CMS determines is necessary to complete its review of the Track Implementation Template, including amendments to the State's CRP Monitoring Plan.

ii. If the State wishes to modify a CRP Track after it has been implemented, the State shall submit to CMS an amended Track Implementation Template no fewer than 120 days before the first day of the PY in which the State intends for the CRP Track modification to be implemented or by such other deadline specified by CMS. The State 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 State's CRP Monitoring Plan. CRP Track modifications must become effective on the date set forth in the Track Implementation Template, as approved by CMS.

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 State to calculate PAU Savings;
3. The methodology that must be used by the Participant Hospital to calculate Incentive Payments;
4. CRP Care Partner Qualifications, if applicable;
5. Instructions requiring each Participant 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 Hospital Participation Agreement.

b. Specify the Intervention Resources it proposes to distribute to Care Partners during the upcoming Performance Year;
c. Identify the cost of each Intervention Resource based on the Participant 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 Hospital Participation Agreement and to identify such criteria in completing the Track Implementation Protocol, and

6. An operational plan, if needed, for any payment modifications.

iv. CMS will make reasonable efforts to approve or reject in writing each proposed or amended Track Implementation Template within 60 days of receipt.
v. If CMS approves a proposed or amended Track Implementation Template, the State shall notify Participant Hospitals that they may choose to implement the CRP Track in the applicable PY in accordance with the newly established Track Implementation Protocol.
vi. The State shall make Track Implementation Protocols available to Participant Hospitals that are interested in participating in the CRP.
vii. 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. CMS shall provide notification to the State prior to updating the CRP Calendar.

e. **CRP Tracks and Alignment with Maryland Payers**. A CRP Track may involve alignment with Maryland 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 Maryland 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 third-party databases, when applicable, in working with Maryland Payers and other stakeholders in the design of CRP Tracks that involve alignment with Maryland Payers.

f. **PAU Savings.**

i. For each CRP Track, the State must develop a methodology to calculate PAU Savings for a Performance Year. Notwithstanding any additional requirements set forth in this Section 12, such methodology must satisfy the following criteria:

a. The methodology measures Medicare cost savings achieved by the Participant Hospital through the reduction of PAU and other savings that the Participant Hospital achieved as a result of the reduced PAU;

b. 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

c. The methodology does not permit duplicate accounting of PAU Savings.

ii. Each Approved Track Implementation Protocol shall describe the PAU Savings methodology State used to calculate PAU Savings for the applicable Participant Hospital.

iii. The State shall notify each Participant Hospital of its PAU Savings for the relevant CRP Track and Performance Year, as required under the Hospital Participation Agreement.

g. **Incentive Payments**

i. For each CRP Track, the State must develop a methodology to calculate Incentive Payments for a Performance Year. The State shall specify in each applicable Track Implementation Template the 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 CRP Care Partner relative to other CRP 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 CRP Care Partners or CRP 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 Medicare FFS Beneficiaries residing in the State.

ii. The State shall ensure that each Participant 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 CRP Care Partner and CRP Downstream Care Partner, respectively.

h. **Intervention Resource Allocation**

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

ii. If the State determines an Intervention Resource Allocation for a Participant Hospital, it shall make such determination based on the following:

1. The Participant Hospital's actual costs for each Intervention Resource, if known, or a reasonable estimate of such costs; and
2. The portion of the Participant Hospital's Intervention Resource Allocation for the previous Performance Year, if any, that was actually spent.

iii. The State may deny funding, in whole or in part, for one or more Intervention Resources specified in the Track Implementation Protocol completed by a Participant Hospital.

iv. The State shall include each Participant Hospital's Intervention Resource Allocation, if any, for the relevant CRP Track and Performance Year in the Participant Hospital's relevant Approved Track Implementation Protocol.

i. **Incentive Payment Pool.**

i. The State shall determine each Participant Hospital's Incentive Payment Pool for a Performance Year by calculating the amount by which PAU Savings achieved by the Participant 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 11.e.i.7 of this Agreement.

ii. The State 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 Participant Hospital's Approved Track Implementation Protocol.

iii. The State shall notify each Participant Hospital of its Incentive Payment Pool, if any, for the relevant CRP Track and Performance Year as required under the Hospital Participation Agreement.

iv. If the State learns that an Incentive Payment Pool determination was calculated incorrectly, it shall notify CMS promptly.

j. **Monitoring the CRP**

i. By the deadlines specified in the CRP Calendar, the State shall develop and submit to CMS a CRP Monitoring Plan, which shall include provisions regarding review of CRP Reports to determine Participant 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 State shall ensure that each Participant 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 Participant Hospital learns that a submitted CRP Report is not true, accurate, or complete, it will promptly submit a revised CRP Report.

iii. If the State 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 State 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 State shall not implement a CRP Monitoring Plan, including a revised CRP Monitoring Plan, that has not been approved by CMS. The State shall monitor the CRP in accordance with the CRP Monitoring Plan most recently approved by CMS.

v. The State shall submit to CMS a report on the State'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 State and CMS shall continue to monitor the Model in accordance with Section 19 of this Agreement.

vii. The State shall promptly notify CMS in writing if it has failed to comply with any of the terms of this Section 12, or if it becomes aware as a result of its monitoring activities or through other means, that a Participant Hospital failed to comply with any of the terms of the Hospital Participation Agreement. Such notice shall specify the noncompliance, the relevant facts, and in the case of a Participant 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.

13. Primary Care AHEAD.

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

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

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

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

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

1. The practice is enrolled in Medicare;
2. The practice delivers primary care in the State;
3. The practice passes a Program Integrity Screening;

4. The practice will not be a concurrent participant in Maryland Primary Care Program (MDPCP) in the upcoming PY;
5. The practice will participate in the Medicaid Advanced PCP in the upcoming PY;
6. The practice is not participating in other models or demonstrations that prohibit concurrent participation in the Model; and
7. If the practice is owned by a health system, the health system hospital that serves the community in which the practice operates will participate in Hospital Global Budgets in the upcoming PY and each subsequent PY that the practice participates in Primary Care AHEAD.

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

v. Prior to PY1, CMS will establish Care Transformation Requirements (CTRs) for Participant Primary Care Practices in accordance with the AHEAD Model requirements and the priorities of the Medicaid Advanced PCP which include activities focused on health-related social needs, care coordination, and behavioral health integration. The State may make recommendations to CMS for revisions to these CTRs for better alignment between Primary Care AHEAD and the State Medicaid Advanced PCP.

vi. The State must provide technical assistance to Participant Primary Care Practices to implement the CTRs in alignment with the State's Medicaid primary care priorities.

vii. If CMS or the State terminates the Implementation Period pursuant to Section 22, the State must notify each Participant Primary Care Practice no later than thirty (30) days prior to the effective date of termination.

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

i. The value of the EPCP in PY1 will be a statewide average of $21 per beneficiary per month (PBPM). CMS will adjust the statewide average EPCP for inflation annually beginning in PY2 and each subsequent Performance Year.

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

iii. CMS will adjust the EPCP amount paid to each Participant Primary Care Practice based on the social and medical risk of the Participant Primary Care Practice's attributed beneficiaries and the Participant Primary Care Practice's performance on select Primary Care AHEAD Quality Measures, as described in Section 13.g., and the Primary Care AHEAD Payment Specifications document. CMS will calculate social and medical risk scores quarterly and quality performance scores annually.

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

d. [Reserved]

e. [Reserved]

f. **Commercial Payer Alignment.** CMS will offer support to the State to facilitate Commercial Payer alignment with primary care transformation under AHEAD.

g. **Primary Care AHEAD Quality Measures.**

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

ii. Subject to CMS' approval, the State may propose alternative primary care measure(s) not listed in Appendix D for implementation in PY1 and subsequent Performance Years.

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

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

1. The State must submit the proposed measure(s) to CMS in writing with a justification explaining the rationale for the alternative measure(s), no later than 180 days prior to the Performance Year for which the measure would take effect.
2. CMS may approve, reject, or request modifications to any such requested measure change at its sole discretion.

14. Maryland Primary Care Program.

a. The MDPCP under this Model is designed to be a continuation of the MDPCP Track 2 implemented under the Maryland Total Cost of Care Model. To the extent CMS determines that the MDPCP under this Model may materially deviate from the MDPCP under the Maryland Total Cost of Care Model, CMS may, in its discretion and upon written notice, unilaterally amend this Agreement to cure any such deviations under Section 14.

b. **MDPCP under AHEAD.** CMS will implement MDPCP Track 2 for PY1 (2026) through PY3 (2028), unless the duration of the MDPCP is modified pursuant to this Agreement. Primary care practices and Care Transformation Organizations ("CTOs") that were participating in MDPCP at the Effective Date of this Agreement shall be considered eligible to participate in the MDPCP. Such practices and CTOs will be provided an MDPCP AHEAD Participation Agreement with CMS that shall be executed prior to PY1 and may be amended each PY in order to continue participation in the MDPCP.

c. For all other practices and entities, the State will direct eligible practices and CTOs to submit information to CMS in a form and manner to be determined by CMS. Primary

care practices, FQHCs, and CTOs that are eligible to participate in the MDPCP will be provided an MDPCP AHEAD Participation Agreement with CMS that shall be executed prior to PY1 and may be amended each PY in order to participate in the MDPCP.

d. The methodologies used to calculate MDPCP payments are described in MDPCP AHEAD Payment Specifications, which CMS will make available to the State. CMS will consult with the State on any revisions to the MDPCP AHEAD Payment Specifications, but all revisions are at CMS' sole discretion.

e. A primary care practice's eligibility for MDPCP beginning in PY2 (2027) and for all subsequent years is contingent on participation in the Medicaid Advanced PCP for that same PY.

f. **Care Management Fees ("CMFs").** CMS will pay primary care practices, FQHCs, and CTOs participating in MDPCP Track 2 a prospective, risk-stratified per-beneficiary per-month CMF based on their number of MDPCP Beneficiaries. CMS will also pay primary care practices, FQHCs, and CTOs participating in MDPCP Track 2 a Health Equity Advancement Resource and Transformation ("HEART") payment as part of the CMF.

g. **Other Primary Care Payments.** CMS will pay those primary care practices, FQHCs, and CTOs participating in the MDPCP Track 2 that do not participate in the Medicare Shared Savings Program as an ACO an at-risk Performance Based Incentive Payment ("**PBIP** ") on a per-beneficiary per-month basis, which must be repaid to CMS in whole or in part by MDPCP Participants or MDPCP Partner CTOs that fail to meet the applicable utilization and quality targets. CMS will also pay primary care practices and FQHCs participating in MDPCP Track 2 a comprehensive primary care payment ("**CPCP** ") calculated in accordance with the terms of the MDPCP AHEAD Participation Agreements.

h. **Beneficiary Attribution**. Under the MDPCP, CMS will attribute Medicare FFS Beneficiaries to MDPCP participating primary care practices and FQHCs for purposes of determining MDPCP payments under MDPCP AHEAD. 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 MDPCP Participants.

i. **Standards for CTOs**. The State shall establish minimum qualifications for CTOs to participate in MDPCP, including but not limited to care transformation responsibilities, staffing, resources and participation in other primary care programs.

j. **Modifications.** In PY3, if an Advanced Alternative Payment Model or other program substantially similar to MDPCP Track 2 is developed by CMS for Primary Care AHEAD and approved for implementation in 2029, CMS and the State will determine whether to extend MDPCP, or transition MDPCP Participants to Primary Care AHEAD. If CMS and the State decide to extend MDPCP, CMS will continue to implement the MDPCP for the duration of the Implementation Period.

15. Quality Payment Program.

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

16. Medicare FFS Beneficiary Protections.

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

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

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

17. Data Sharing.

a. **Health Oversight Agency.** The State represents that it is a Health Oversight Agency and include assertions in Appendix G and Appendix H from the HSCRC and MDH as to their status as "health oversight agencies" (as that term is defined in 45 CFR § 164.501) in the context of this Model. The State must maintain its status as a Health Oversight Agency throughout the Implementation Period. If the State loses its status as a Health Oversight Agency, CMS will consider this to be a Triggering Event subject to an

enforcement action, as described in Section 22.b., and CMS will no longer share Medicare FFS Beneficiary data with the State.

b. **CMS Data Sharing.**

i. During the Agreement Term, CMS will offer the State an opportunity to request certain Medicare data and reports using a data request form and data request process to be determined in a form, manner, and time by CMS. All such requests for beneficiary-identifiable information must clearly state which provision under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule permits the requested disclosure (e.g., for health oversight activities under 45 C.F.R. § 164.512(d)). CMS will ensure that this Medicare data is provided to the State in a manner consistent with all applicable laws and regulations, including HIPAA. CMS will make best efforts to approve, deny, or request additional information within 30 days of receipt. CMS will accept or reject such requests on a case-by-case basis and at CMS' sole discretion.

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

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

i. The State is expected to use the requested data in its efforts to monitor and oversee 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 beneficiary-identifiable data received under this Agreement to Model participants. Such disclosures may be made without prior authorization from CMS if such disclosure is necessary to enable the State's oversight of the Model, or to enable quality improvement activities or health care provider incentive implementation.

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

iii. The State must use appropriate privacy and security protections for any data used and disclosed under this Model, in accordance with applicable law and CMS policies.

d. **State Data Reporting Requirements.**

i. In accordance with 42 C.F.R. § 403.1110(b), the State must collect and report to CMS all-payer health care spending and population health outcome data, all-payer primary care spending data, and access and quality metric data on an annual basis that is necessary to support CMS monitoring and evaluation of the Model. The State must retain such documentation in accordance with Section 25.

ii. The State must ensure that Participant Hospitals, MDPCP Participants, MDPCP Partner CTOs, and Participant Primary Care Practices submit to CMS any data requested by CMS as part of the monitoring and evaluation of the Model.

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

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

e. **Primary Care Spending Data Sharing**.

i. The State must provide to CMS all-payer primary care spending data for monitoring, evaluation, and calculation of All-Payer Primary Care Investment Targets no later than 15 months after the end of each Performance Year. This data must include primary care spending of all commercial and Medicaid payers, including, but not

limited to, Medicare Advantage plans, State Medicaid spending, and state employee health plans.

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

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

18. Confidentiality.

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

19. Monitoring.

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

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

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

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

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

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

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

v. The State must submit reports to CMS in accordance with the requirements of Section 20 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.

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

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

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

20. Reporting.

a. **Annual Progress Report**: The State must submit to CMS an Annual Progress Report, following the end of each PY, as described in this Section 20, providing updates on the State's performance and activities from the preceding PY.

i. For the Annual Progress Report submitted in PY1 (due on March 31, 2026), the State must provide updates on the State's performance and activities that occurred during the Pre-Implementation Period. The Annual Progress Report due March 31, 2026, is referred to as Annual Progress Report 2 in the Cooperative Agreement.

ii. For the Annual Progress Report submitted for PY2 and each subsequent PY, the State must submit an Annual Progress Report due on June 30th following the end of each PY.

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

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

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

iii. Updates regarding the State's efforts to align Commercial Payers to Primary Care AHEAD, including breakdowns by Commercial Payer;

iv. Updates regarding the funding sources of the Population Health Trust and the use of the funds for activities in support of the Statewide Health Equity Plan and Statewide Population Health Targets.

v. Narrative regarding updates in the Statewide Health Equity Plan, including:

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

vi. Updates on MDPCP implementation under AHEAD and activities performed by the State to further the success of MDPCP.

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

c. Statewide Health Equity Plan

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

ii. Beginning with the Annual Progress Report for Performance Year 1 (due June 30, 2027) and each Annual Progress Report thereafter, the State must submit performance data on Statewide Quality and Equity Targets.

d. **Hospital Health Equity Plan.**

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

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

e. The State may request an extension to reporting deadlines specified in this Section 20, for all or part of the information required, which CMS may approve or reject. The State must submit its request for an extension at least thirty (30) days before the applicable reporting deadline.

21. Model Evaluation.

a. **CMS Evaluation.**

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

ii. The State must cooperate with CMS and/or CMS' designee(s) and provide all data that the State is required to provide under the provisions of Section 17 of this Agreement or that CMS may request from the State to evaluate and monitor the Model in accordance with applicable law and this Agreement. Such data may include, but would not be limited to, beneficiary-identifiable information that is needed to carry out CMS's evaluation and monitoring of this Model and the terms of

any arrangements related to rate- or budget-setting or payment entered into between the State, Participant Hospitals, MDPCP Participants, MDPCP Partner CTOs, and Participant Primary Care Practices prior to or during the Model.

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

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

22. Enforcement Action and Termination.

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

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

1. A determination by CMS that the Model has had one or more of the following effects not otherwise enumerated as a Triggering Event: negative consequences for Medicare providers and Medicare FFS Beneficiaries; State not providing Model participants with adequate resources; State is not facilitating savings or improving quality as intended; or effects of the model are otherwise not aligned with the Model's goals or the State's methodology.
2. CMS determines that the State has failed to demonstrate that the State's hospital quality and value-based payment programs described in Section 11.h. achieved or surpassed the measured results in terms of Medicare patient outcomes and Medicare cost savings as those programs established under Sections 1886(o), 1886(p), and 1886(q) of the Act in any two PYs within a period of three consecutive PYs.
3. A determination by CMS that the State has failed to meet the Statewide Quality and Equity Targets for PYs 2, 4, 6, or 8.

4. A determination by CMS that the State has failed to meet the All-Payer TCOC Growth Target in any two PYs within a period of three consecutive PYs.
5. A determination by CMS that the State failed to meet the Statewide Population Health Targets for PYs 2, 4, 6, or 8.
6. A determination by CMS that the State has failed to meet the All-Payer Primary Care Investment Targets in any two PYs within a period of three consecutive PYs.
7. A determination by CMS that the State has failed to operate a Medicaid Advanced PCP starting in PY1 and each PY of the Model thereafter.
8. A determination by CMS that the State failed to ensure that MDPCP Participants participate in the Medicaid Advanced PCP during PY2 and each PY thereafter or that the State failed to ensure Participant Primary Care Practices participate in the Medicaid Advanced PCP during PY1 and each PY thereafter.
9. A determination by CMS that the State has failed to include Medicaid in the Hospital Global Budget prior to the end of PY 1 and each PY of the Model thereafter.
10. A determination by CMS that the State has not established All-Payer TCOC Growth Targets for PYs 2 through 5, at a minimum, by PY2.
11. A determination by CMS that the State has not established All-Payer Primary Care Investment Targets for PYs 2 through 5, at a minimum, by PY 2.
12. A determination by CMS that the State has failed to meet the Medicare FFS Primary Care Investment Target in any two PYs within a period of three consecutive PYs.
13. A determination by CMS that the State has failed to meet the Medicare FFS TCOC Target in any two PYs within a period of three consecutive PYs.
14. A determination by CMS that the State is materially noncompliant with the terms and conditions of the Cooperative Agreement or fails to meet the Model milestones within the Cooperative Agreement.
15. CMS' termination of the State's Cooperative Agreement.
16. A determination by CMS that the number of Medicare FFS Beneficiaries residing within the State has fallen below 10,000.

17. A determination by CMS that less than 90 percent of all Regulated Revenue for Maryland residents is paid according to the CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology for any PY.
18. A determination by CMS that the State has failed to meet the Revenue at Risk standard described in Section 11.e.
19. A determination by CMS that the State has failed to materially comply with the requirements of this Agreement.
20. A determination by CMS that the State has taken any action that threatens the health or safety of a Medicare FFS Beneficiary or other patient.
21. A determination by CMS that the State has taken actions that compromise the integrity of the Model or the Medicare Trust Funds.
22. The State fails to continue to set Hospital Global Budgets for all Commercial Payers pursuant to its authority under Md. Code Ann. Health-Gen. §19-201 et seq. and *NY State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co*., 514 U.S. 645 (1995).
23. The State fails to maintain its status as a Health Oversight Agency as described in Section 17.a.
24. A determination by CMS that the quality of care provided to Medicare, Medicaid, or CHIP beneficiaries has deteriorated at any point in time throughout the Model.
25. If the State submits false data or makes false representations, warranties, or certifications in connection with any aspect of the Model.
26. If the State enacts legislation, implements regulation, or takes any other action that inhibits the ability of the State and/or Maryland Payers to participate in the Model, and CMS determines that such changes and/or actions are not consistent with the requirements of this Agreement.

c. **Triggering Event Factors.**

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

ii. The State may demonstrate, in accordance with the process described in Section 22.e., that an Exogenous Factor caused the Triggering Event, in whole or in part;

or whether a delay in a CMS deliverable required of CMS under this Agreement contributed to the Triggering Event.

d. **Changes to Payments.**

i. CMS may adjust Medicare FFS payments under the Model to Participant Hospitals via the MPA, the EPCP made to the Participant Primary Care Practices, and payments made to MDPCP Participants and MDPCP Partner CTOs if the following determination or request occurs:

1. If CMS determines a Triggering Event has occurred and the adjustment is intended to correct the Triggering Event; or
2. If the State requests an adjustment to one or more payments described in Section 22.d.i before CMS has determined a Triggering Event has occurred and the adjustment is intended to result in performance that avoids a Triggering Event.

e. **Warning Notice.**

i. If CMS determines that a Triggering Event, as defined in Section 22.b., has occurred, CMS will provide written notice to the State ("**Warning Notice**") with an explanation and, to the extent practicable and permitted by applicable law, data supporting its determination.

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

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

f. **Enforcement Action Notice.** If CMS does not accept the State's response to the Warning Notice as sufficient, CMS may issue a written notice ("**Enforcement Action Notice**"), to the State, outlining the enforcement action(s) CMS is taking against the State. CMS may take one or more of the following enforcement actions:

i. Require the State to submit and implement a corrective action plan (CAP) in accordance with Section 22.g.;

ii. Require the State to provide additional information to CMS;

iii. Subject the State to additional monitoring, auditing, or both;

iv. Require the State to propose to CMS for approval new safeguards or programmatic features to be added to the Model;

v. Modify or terminate a Medicare payment waiver or waivers identified in paragraphs 3 through 12 of the list of "Medicare Payment Waivers" or the list of "Benefit Enhancements" in Appendix E of this Agreement.

g. **Corrective Action Plan.**

i. The State must submit a CAP to CMS within 45 days of receipt of an Enforcement Action Notice requiring a CAP. The CAP must describe actions the State and, if applicable, other participants in the Model, will take, including any specific corrective actions detailed by CMS in the Enforcement Action Notice, within the time period specified in the Enforcement Action Notice, to ensure any deficiencies will be corrected and that the State, and other participants in the Model if applicable, will be in compliance with the terms of this Agreement.

ii. The Enforcement Action Notice will provide a specified period of time the State has to implement the terms of the CAP.

iii. CMS will review and approve, or require modifications to, the proposed CAP within 45 days of receipt.

iv. The CMS-approved CAP will provide the State the criteria, timeframe, and a process for successful completion of the CAP.

v. If CMS determines the State has failed to submit, obtain approval for, implement successfully, or fully comply with the terms of a CAP required by 22.g. and the CAP was required due to a Triggering Event listed in 22.b.9. through 22.b.26., CMS may take one or more of the following actions:

1. Modify or terminate Medicare payment waiver or waivers identified paragraphs 1 and/or 2 of the list of "Medicare Payment Waivers" in Appendix E of this Agreement;
2. Take additional enforcement actions described in Section 22.f.
3. Terminate any Participation Agreement related to the Model;

4. Terminate the Pre-Implementation Period or the Implementation Period of the Model; or
5. Terminate this Agreement.

h. **Termination by CMS.** CMS may immediately or with advance notice terminate the Model, a Participation Agreement, the Implementation Period and/or Transition Period of the Model, or this Agreement if CMS, in its sole discretion, determines that:
   i. the State has failed to submit, obtain approval for, successfully implement, or fully comply with the terms of a CAP required by Section 22.g. and the CAP was required due to a triggering event listed in Section 22.b.9. through b.26; or
   ii. the State has not timely complied with an enforcement action required by CMS pursuant to Section 22.f.ii. through f.v., provided such enforcement action was due to a triggering event listed in Section 22.b.9. through b.26.

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

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

23. Limitations on Review and Dispute Resolution.

a. **Limitation on Review.** There is no administrative and judicial review under Sections 1869 and 1878 of the Act or otherwise for the following:
   i. The selection of states, organizations, sites, or participants in the Model, including the decision by CMS to terminate this Agreement or to require the termination of any individual's or entity's status or participation in the Model;
   ii. The selection of models for testing or expansion under Sections 1115A of the Act;
   iii. The elements, parameters, scope, and duration of the Model, including methodologies and calculations developed under the Model, as discussed herein, and the Cooperative Agreement;
   iv. The termination or modification of the design and implementation of the Model under Section 1115A(b)(3)(B) of the Act;
   v. Determinations regarding budget neutrality under Section 1115A(b)(3) of the Act; and

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

b. **Dispute Resolution**.

i. The Parties agree to the following procedures for any dispute that is not subject to preclusion of administrative or judicial review as set forth in Section 23.a. or any dispute related to a CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology requirements or calculations.

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

iii. If the Parties cannot resolve any such dispute within 30 calendar days after CMS receives written notice of the dispute, then the State must submit within 30 subsequent calendar days a request for an informal hearing to an independent CMS hearing officer, or an independent CMS designee, including the detailed explanation of the basis for the dispute and supporting documentation.

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

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

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

notification of the independent CMS hearing officer's determination. The CMS Administrator's decision is final and binding.

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

24. Federal Government Enforcement

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

b. This Agreement shall not be construed to bind any Federal government agency except CMS, and this Agreement binds CMS only to the extent provided herein. The failure by CMS to require performance of any provision shall not affect CMS' right to require performance at any time thereafter, nor shall a waiver of any breach or default of this Agreement constitute a waiver of any subsequent breach or default or a waiver of the provision itself. None of the provisions of this Agreement limit or restrict the OIG's authority to audit, evaluate, investigate, or inspect the State, hospitals or providers and/or suppliers in the State, or individuals or entities performing functions or services related to activities under this Agreement.

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

25. Maintenance of Records.

a. In accordance with applicable law, the State must maintain and give CMS and other applicable HHS agencies, the Department of Justice, the Government Accountability

Office, and other federal agencies or their designees access to all books, contracts, records, documents, software system, and other information (including data related to calculations required under the Model Agreement, Medicare utilization and costs, quality performance measures, and financial arrangements) sufficient to enable the audit, evaluation, inspection, or investigation of the State's compliance with the requirements of this Agreement.

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

26. Survival.

a. Termination of the Agreement or expiration of the Agreement Term shall not affect the rights and obligations of the Parties accrued prior to the effective date of the termination or expiration of the Agreement or Agreement Term, except as provided in this Agreement.

b. The rights and duties under the following sections of this Agreement must survive its termination or expiration and apply for a period of three (3) years from the termination or expiration of this Agreement:
    i. Section 19 (Monitoring); and
    ii. Section 21 (Model Evaluation).

c. The rights and duties under the following sections must survive the termination of the Agreement or expiration of the Agreement Term and apply for a period of ten (10) years from the termination or expiration of this Agreement:
    i. Section 17 (Data Sharing); and
    ii. Section 25 (Maintenance of Records).

27. 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.

28. Severability.

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

29. Notice.

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

To the State:

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

Executive Director
Jon.Kromm@maryland.gov or successor
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

To CMS:

Director, Division of Multi-Payer Models

Katherine.Sapra@cms.hhs.gov or successor

Center for Medicare and Medicaid Innovation

7500 Security Boulevard

Baltimore, MD 21244

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

30. Modification.

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

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

c. To the extent practicable, CMS will provide the State with 30 days advance written notice of any unilateral amendment, which notice will specify the amendment's effective date. If such amendment violates the law of the State, the Parties will promptly seek modification of the amendment. If modification of the amendment is impracticable or consensus cannot be reached, CMS may terminate the Implementation Period, any waivers under the Model, and/or this Agreement in accordance with Section 22 of the Agreement.

31. Entire Agreement.

This Agreement, including all Recitals and Appendices, constitutes the entire agreement between the Parties. The Parties may amend this Agreement or any Appendix hereto pursuant to Section 30 except as otherwise noted in this Agreement or any Appendix hereto.

32. Precedence.

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

[SIGNATURE PAGE FOLLOWS]

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

Date: Nov 1, 2024

By: _____

Liz Fowler

GOVERNOR OF THE STATE OF MARYLAND

Date Nov 1, 2024

By: _____

Governor Wes Moore

SECRETARY OF HEALTH OF THE STATE OF MARYLAND

Date Nov 1, 2024

By: _____

Laura Herrera Scott

CHAIR OF THE HEALTH SERVICES COST REVIEW COMMISSION

Date 11/1/24

By: _____

Joshua Sharfstein

Appendix A: Calculation Methodology for the Medicare FFS TCOC Targets

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

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

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

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

"Trend Factor" is the annual growth rate, calculated as the United States Per Capita Cost (USPCC), adjusted to align with the inclusions and exclusions used to calculate Medicare FFS PBPY expenditures . The Trend Factor is designed to match the expected TCOC growth in the absence of Model participation.

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

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

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

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

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

Calculation Methodology:

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

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

Table 1: Baseline Year Weights

Baseline Year	**Calendar Year**	**Weighting**	**Baseline Year Spending PBPY**
Baseline Year 1	2021	0%	Not applicable
Baseline Year 2	2022	0%	Not applicable
Baseline Year 3	2023	100%	$14,107

(Weighting will be applied in Step 3).

Step 2: Apply Risk Adjustment to each BY to standardize historical spending to a 1.0 score basis relative to national. Risk adjustment will account for beneficiary demographics and health conditions within the State. For each of the baseline years, CMS will divide Baseline Year Spending by the State's average normalized Hierarchical Condition Categories (HCC) score for that baseline year. The State's average normalized HCC score will be determined by applying the 2024 CMS-HCC Risk Adjustment Model (Version 28) to claims from the baseline year for all Medicare FFS Beneficiaries who resided in the State during the baseline year. Beneficiary normalized HCC scores will be weighted using the number of months each beneficiary resided in the State to construct the State average normalized HCC score.

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

Step 4: Determine the Trend Factor. The Trend Factor is the adjusted USPCC, which represents a mechanism to update Baseline PBPY to the applicable PY.

In determining the Trend Factor for the applicable PY, the adjusted projected USPCC (that is, a prospective estimate of the growth rate for the upcoming year) will be included for the current PY's component of the Trend Factor, the average of the adjusted projected USPCC (prospective estimate) and the adjusted observed USPCC (actual historical) will be used for the previous PY, and the adjusted observed USPCC (actual historical) will be included for Trend Factor components pertaining to all remaining elapsed PYs and calendar years between BY3 and PY1, as applicable.

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

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

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

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

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

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

BY = baseline year

PY = Performance Year

TF = Trend Factor

SC = Savings Component

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

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

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

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

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

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

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

Medicare FFS TCOC Target (Step 7) =

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

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

a. CMS will calculate Medicare FFS expenditures for a given PY by adding together the following two fractions: (a) Medicare Part A expenditures per Medicare FFS Beneficiary with Part A residing in the State; and (b) Medicare Part B expenditures per Medicare FFS Beneficiary with Part B residing in the State.
    i. The calculation of Medicare FFS expenditures will include all Part A and Part B expenditures for State resident Medicare FFS Beneficiaries, regardless of the state of service. As described in Section 8.b. below, any Outcome-Based Credit amount deemed approved will be applied as a reduction to the calculation of all such Medicare Part B expenditures.
    ii. The calculation of Medicare FFS expenditures will include non-claims based payments.
    iii. The number of State resident Medicare FFS Beneficiaries with Part A and State resident Medicare FFS Beneficiaries with Part B will be determined

using average monthly enrollment during the 12 months of the Performance Year.

iv. To determine the Medicare Part A expenditures per Medicare FFS Beneficiary with Part A residing in the State, CMS will divide the total Part A expenditures as calculated in accordance with Step 8.a.i. of this Appendix above by the number of State resident Medicare FFS Beneficiaries with Part A as calculated in accordance with Step 8.a.iii. of this Appendix.

v. To determine the Medicare Part B expenditures per Medicare FFS Beneficiary with Part B residing in the State, CMS will divide the total Part A expenditures as calculated in accordance with Section 8.a.i. above by the number of State resident Medicare FFS Beneficiaries with Part B as calculated in accordance with Step 8.a.iii. of this Appendix.

vi. CMS and the State understand that Medicare billing rules and requirements may change during the Agreement Term. Consistent with Section 30 of this Agreement, CMS and the State may amend this Agreement to modify the savings calculation methodology described in this Appendix A.

b. CMS will include the amount of Outcome-Based Credits deemed approved in accordance with Section 10.a.iii.2. in the calculation of the Medicare FFS PBPY expenditures for that Performance Year. Specifically, any Outcome-Based Credit amount deemed approved will be applied as a reduction in Medicare Part B expenditures for that PY.

Step 9: Compare the actual Medicare FFS national annual growth rate (adjusted observed USPCC) to the projected Medicare FFS national annual growth rate (adjusted projected USPCC) for the PY. Following each PY, CMS will compare the adjusted observed USPCC to the adjusted projected USPCC used in Step 4 to calculate the Trend Factor for the applicable PY. If the adjusted observed USPCC deviates from the adjusted projected USPCC by more than 1 percentage point, in either direction, CMS will add half of the difference between the adjusted observed and adjusted projected USPCC beyond one percentage point to the adjusted projected USPCC and will calculate a revised Trend Factor and Medicare FFS TCOC Target for the applicable PY. This reconciled USPCC will be used to calculate the revised Trend Factor for the applicable PY in accordance with the methodology described in Step 4.

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

Appendix B: Medicare FFS Primary Care Investment Target

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

Medicare FFS Primary Care Investment Target Methodology

CMS will measure the State's performance on the Medicare FFS Primary Care Investment Target for each Performance Year using the following equation calculated for Maryland beneficiaries covered by Medicare Parts A and B:

$$State\ Performance\ for\ a\ Given\ Performance\ Year = \frac{Sum\ of\ Medicare\ FFS\ Primary\ Care\ Expenditures\ in\ that\ PY}{Medicare\ FFS\ TCOC\ in\ that\ PY}$$

The **Sum of Medicare FFS Primary Care Expenditures** in the Performance Year will be calculated by CMS based on Medicare FFS claims for a CMS-specified list of specialty codes, Healthcare Common Procedure Coding System codes, and non-claims-based payments for services provided to Maryland beneficiaries with both Medicare Parts A and B. In advance of each Performance Year, CMS will provide the State with the list of codes that will be included in the calculation of the **Sum of Medicare FFS Primary Care Expenditures** for that Performance Year for purposes of assessing the State's performance on the Medicare FFS Primary Care Investment Target.

The **Medicare FFS TCOC expenditures** in the Performance Year is the State's Medicare FFS PBPY expenditures calculated by CMS in accordance with Steps 1-8 of the methodology set forth in Appendix A of this Agreement for the applicable Performance Year when applied only to Maryland beneficiaries covered by both Medicare Parts A and B.

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

Performance Year	Annual Medicare FFS Primary Care Investment Target
PY1	4.9%
PY2	4.9%
PY3	4.9%
PY4	4.9%
PY5	4.9%
PY6	4.9%
PY7	5.1%
PY8	5.1%
PY9	5.1%

Appendix C. Calculation Methodology Requirements for Hospital Global Budgets

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

General Requirements.

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

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

3. The Proposed State-Designed All-Payer Hospital Global Budget Methodology must account for inflation, population growth, demographic changes, and other factors influencing the cost of hospital care. In addition, Hospital Global Budgets must be adjusted for both medical and social risk for either Maryland residents the hospital serves or the hospital's geographic service area.

4. The Proposed State-Designed All-Payer Hospital Global Budget Methodology must include a mechanism by which a Participant Hospital's Hospital Global Budget is adjusted for hospital-level quality performance based on the quality outcomes of an attributed patient population. This quality adjustment must be based on performance on either the CMS national hospital quality programs or on similar categories of quality measures to those used for these programs. Hospital Global Budgets must be adjusted for performance using disparities-sensitive quality measures aimed at improving health equity. At a minimum, the selected measures must provide sufficient data to identify disparities and improvements in health equity, and the measures must align with the overall model goals.

5. The Hospital Global Budget Methodology must account for changes in service line and unplanned volume shifts, while continuing to avoid incentivizing FFS-oriented utilization. The State must clearly state the process for accounting for these changes in the Hospital Global Budget, including identifying these or other circumstances under which this process would occur (e.g., FFS prospective budget payments, hospital service

line changes, eligibility updates, other unplanned programmatic changes beyond a certain revenue threshold, etc.).

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

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

1. **Prospective payment:** Participant Hospitals will receive a fixed payment amount as calculated in the State-Designed All-Payer Hospital Global Budget methodology at regular, specified intervals (e.g., biweekly, monthly) over the course of the PY. Following each PY, the State must complete a review process of each Participant Hospital's Hospital Global Budget to adjust for performance, quality, market shifts, and other factors as outlined in the State- Designed Hospital Global Budget Methodology.
2. **Virtual global budget:** Under this option, payers pay fee-for-service claims. The State must develop and administer a defined reconciliation process to true up the claims payments against the prospectively set Hospital Global Budgets.

Appendix D: Primary Care AHEAD Quality Measures

Domain	Measure	Identifier	Steward	Data Source	Payer and Program Alignment
Behavioral Health (30%) Measure is Required	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	‡CBE 0418e; CMIT 672	CMS	eCQM	Medicaid Adult Core Set; Commercial; Making Care Primary; CPC; UDS
Prevention & Wellness (15%) Choose at least 1	*Colorectal Cancer Screening (COL-AD)	CBE 0034 CMIT 139	NCQA	eCQM	Medicaid Adult Core Set; Commercial; Making Care Primary; Primary Care First; CPC+; CPC; UDS
	*Breast Cancer Screening: Mammography (BCS-AD)	CBE 2372 CMIT 93	NCQA	eCQM	Medicaid Adult Core Set; Medicare; Marketplace; Commercial; CPC+; CPC; UDS
Chronic Conditions (15%) Choose at least 1	*+^Controlling High Blood Pressure (CBP-AD)	CBE 0018 CMIT 167	NCQA	eCQM	Medicaid Adult Core Set; Medicare; Marketplace; Commercial; Making Care Primary; Primary Care First; CPC+; CPC; UDS
	*+^ Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	CBE 0059 CMIT 204	NCQA	eCQM	Medicaid Adult Core Set; Medicare; Marketplace; Making Care Primary; Primary Care First; CPC+; CPC; UDS
Health Care Utilization (40%) Both measures are required	Emergency Department Utilization (EDU)	N/A	NCQA	Claims	Commercial; Making Care Primary; CPC+
	Acute Hospital Utilization (AHU)	N/A	NCQA	Claims	Commercial; Primary Care First; CPC+

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

CMIT = Centers for Medicare & Medicaid Services Measures Inventory Tool

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

*Included in CMS Universal Foundation

+ Aligned with CMCS Health Equity Set

‡ = Measure is no longer endorsed by the CBE

^Aligned with Medicare Advantage

Appendix E: Medicare Payment Waivers and Benefit Enhancements

Medicare Payment Waivers

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

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

Benefit Enhancements

Subject to the provisions of this Agreement and the applicable Participation Agreement, and as specified in this Appendix, CMS will waive the requirements of the following provisions of the Act, as necessary, for purposes of testing the Model, and providing Participant Hospitals and Participant Primary Care Practices, as applicable, the opportunity to provide Benefit

Enhancements, subject to certain requirements in their associated Participation Agreement and applicable statutes, rules or regulations administered by the Federal government.

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

Appendix F: All Payer Revenue Limit and Specifications for Calculations

I. Definitions

"All Payers" means Medicare 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 Participant Hospitals from All Payers. The Growth Limit is 3.58 percent, unless replaced by an alternative proposed by the State and approved by CMS in accordance with Section 10.h.

"Population Growth Percentage" means the percentage increase in Maryland's population for a Performance 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 Participant 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 2026 through the end of the Implementation Period, the State will calculate a compounding factor equal to (1 + the Growth Limit for that Performance Year) multiplied by (1 + the Population Growth Percentage for that Performance Year ("**Compounding Factor"**).

2) For a given Performance Year, the Base Period Revenue will be multiplied by the Compounding Factor, for every calendar year between the Base Period and the current Performance Year, to yield the maximum revenue that Participant Hospitals may earn in that Performance 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 Performance 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 F.

2) The State may adjust Regulated Gross Patient Service Revenue for a Performance Year to reflect an increase in the Public Payer Differential proposed by the State and approved by CMS pursuant to Section 11.d. of the Agreement.

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

By May 1 of each Performance Year, beginning in PY1, the State will divide the Regulated Gross Patient Service Revenue for the prior calendar 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 G: MDH Attestation and Data Specification Worksheet

HIPAA-Covered Disclosure Request Attestation

The Maryland Department of Health (MDH) requests the CMS data listed in the Data Specification Worksheet below and makes the following assertions regarding its ability to meet the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requirements for receiving such data:

- The MDH affirms that it is a "health oversight agency" as defined in 45 C.F.R. § 164.501 and represented in Section 17 (Data Sharing) of this Agreement.

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

- For its own "oversight activities" as a "health oversight agency" that fall within the "oversight activities" of the definition of that phrase under the HIPAA Privacy Rule (45 C.F.R. §164.512(d)(1)).
- Other: Please attach a description of the intended use.

The MDH requests (select one):

- For the Medicare FFS beneficiaries who reside in Maryland that have been aligned to Participant Hospitals and Participant Primary Care Practices and MDPCP Participants under the Model using the described in this Agreement: (i) three years of historical data files for each performance year of the Model consisting of the data elements identified in the Data Specification Worksheet for Initiative Beneficiaries; and (ii) monthly claims data files for all Initiative Beneficiaries for the data elements identified in the Data Specification Worksheet, from the following CMS Integrated Data Repository (IDR) data files:
    - IDR Medicare Part A and Part B claims and eligibility data (NOTE: file name TBD)
    - IDR Medicare Part D data (DRX09 - IDR RESTRICTED ACCESS TO LIMITED MEDICARE PART D CLAIM DATA (NO FINANCIAL PAYMENT COLUMNS).)
- Other: Please attach a detailed description of the data requested.

The data requested is (select one):

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

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

1. Brandon Neiswender
   Chesapeake Regional Information Systems for Our Patients (CRISP)
   10480 Little Patuxent Pkwy Suite 800, Columbia, MD 21044
   Brandon.Neiswender@crisphealth.org
   443-285-0162

2. George Chalissery
   hMetrix
   150 Monument Rd, Suite 203, Bala Cynwyd PA, 19004
   george@hmetrix.com
   610-668-1961

3. James Clavin, CTO
   The Hilltop Institute at University of Maryland, Baltimore County (UMBC)
   Sondheim Hall, Third Floor, 1000 Hilltop Circle, Baltimore, MD 21250
   jclavin@hilltop.umbc.edu
   410-455-6518

4. Ryan Andersen
   Milliman
   1301 Fifth Avenue, Suite 3800
   Seattle, WA 98101 USA
   Ryan.Andersen@Milliman.com
   Mobile +1206 786 9485

Data Specification Worksheet

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix H: HSCRC Attestation and Data Specification Worksheet

HIPAA-Covered Disclosure Request Attestation

The Maryland Health Services Cost Review Commission (HSCRC) requests the CMS data listed in the Data Specification Worksheet below and makes the following assertions regarding its ability to meet the HIPAA requirements for receiving such data:

- The HSCRC affirms that it is a "health oversight agency" as defined in 45 C.F.R. § 164.501 and represented in Section 17 (Data Sharing) of this Agreement.

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

- For its own "oversight activities" as a "health oversight agency" that fall within the "oversight activities" of the definition of that phrase under the HIPAA Privacy Rule (45 CFR §164.512(d)(1)).
- Other: Please attach a description of the intended use.

The HSCRC requests (select one):

- For the Medicare FFS Beneficiaries who reside in Maryland that have been aligned to Participant Hospitals and Participant Primary Care Practices and MDPCP Participants under the Model using the described in this Agreement: (i) three years of historical data files for each performance year of the model consisting of the data elements identified in the Data Specification Worksheet for Initiative Beneficiaries; and (ii) monthly claims data files for all Initiative Beneficiaries for the data elements identified in the Data Specification Worksheet, from the following CMS Integrated Data Repository (IDR) data files:
    - CCRAF - CM/CMMI CENTRAL REPOSITORY OF ALIGNMENT FILES
    - EDB - ENROLLMENT DATA BASE,
    - HCC - HEALTH CARE CHARACTERISTICS RISK SCORE
    - MBSF - MASTER BENEFICIARY SUMMARY FILE
    - MDD - MASTER DATA MANAGEMENT,
    - PQRSSD - PQRS SUBMISSION DATA
    - IDR Medicare Part A and Part B claims and eligibility data (NOTE: file name TBD)

- IDR Medicare Part D data (DRX09 - IDR RESTRICTED ACCESS TO LIMITED MEDICARE PART D CLAIM DATA (NO FINANCIAL PAYMENT COLUMNS).)

- Other: Please attach a detailed description of the data requested.

The data requested is (select one):

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

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

1. Brandon Neiswender
   Chesapeake Regional Information Systems for Our Patients (CRISP)
   10480 Little Patuxent Pkwy Suite 800, Columbia, MD 21044
   Brandon.Neiswender@crisphealth.org
   443-285-0162

2. George Chalissery
   hMetrix
   150 Monument Rd, Suite 203, Bala Cynwyd PA, 19004
   george@hmetrix.com
   610-668-1961

3. Ryan Andersen
   Milliman
   1301 Fifth Avenue, Suite 3800
   Seattle, WA 98101 USA
   Ryan.Andersen@Milliman.com
   Mobile +1206 786 9485

Data Specification Worksheet

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix I: Statewide Quality Measures

Table 1. Core Statewide Measures

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

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

* Included in CMS Universal Foundation

+ Aligned with CMCS Health Equity Set

^ Aligned with Medicare Advantage

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

CMIT = Centers for Medicare & Medicaid Services Measures Inventory Tool

Table 2. Statewide Optional Measures

Domain	**Measure**	**Identifier**	**Steward**	**Payer Alignment**	**Data Sources**
Maternal Health Outcomes *Choose at least 1*	+Live Births Weighing Less than 2500 grams (LBW-CH)	CBE 1382 CMIT 413	CDC/NCHS	Medicaid and CHIP Child Core Set	State vital records
	+Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	CBE 1517 CMIT 581	NCQA	Medicaid Adult Core Set; Marketplace	Claims or hybrid

Prevention Measures *Choose at least 1*	*Adult Immunization Status	CBE 3620 CMIT 26	NCQA	Commercial	Claims, Electronic Health Data, EHR, Enrollment Data, Management Data, Registry Data
	Prevalence of Obesity	____		____	BRFSS
	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	CBE 0027 CMIT 432	NCQA	Medicaid Adult Core Set	Survey
	ED Visits for Alcohol and Substance Use Disorders[#]	CMMI in-house measure	CMS	Not Available Yet	Claims
Social Drivers of Health *Choose at least 1*	Food Insecurity	____		____	USDA Current Population Survey or equivalent
	Housing Quality	____		____	American Housing Survey; Census Bureau or equivalent

* Included in CMS Universal Foundation

+ Aligned with CMCS Health Equity Set

[#] Measure in development by CMMI with Yale CORE