

Maryland All-Payer Model Agreement First Amendment

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

The purpose of this amendment is to make certain changes to the Agreement and to modify the Maryland All-Payer Model to require the State to implement a care redesign program in which Regulated Maryland Hospitals may participate on a voluntary basis. The care redesign program is intended to enable hospitals to incent physicians and other health care providers to engage in care redesign activities that will support state-wide efforts to reduce the growth in total cost of care (“TCOC”) for Medicare FFS beneficiaries and facilitate the State’s transformation to a TCOC reimbursement model.

The parties therefore amend the Agreement as set forth below.

1. Effective Date. This amendment shall be effective when it is signed by the last party to sign it (as indicated by the date associated with that party’s signature).
2. Medicare Payment Waivers. Section 4 of the Agreement is hereby amended as follows:
 - a. Paragraph (e) is hereby amended to replace “the Secretary” with “the Secretary of the Department of Health and Human Services (“Secretary”).”
 - b. The last paragraph is hereby amended in its entirety to read as follows:

CMS reserves the right to modify or revoke any waiver of Medicare payment requirements stated above (“Waiver”) or as applicable, to terminate this Agreement, pursuant to the procedures set forth in Section 14, if Maryland does not comply with the conditions associated with the applicable Waiver as set forth in this Agreement.

3. Fraud and Abuse Waivers. Section 5 of the Agreement is hereby amended in its entirety to read as follows:

Fraud and Abuse Waivers. *Financial arrangements between and among providers and suppliers must comply with all applicable fraud and abuse laws and regulations, except as may be explicitly provided in a waiver issued specifically for the Model pursuant to section 1115A(d)(1) of the Act. The Secretary may consider issuing one or more waivers of certain fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act (each, a “Fraud and Abuse Waiver”), as may be necessary solely for purposes of*

carrying out this Model. Such Fraud and Abuse Waivers, if any, would be jointly issued by CMS and OIG and would be set forth in a separately issued document. Any such waiver would apply solely to this Model and could differ in scope or design from 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.

4. Care Redesign Program. Section 8 of the Agreement is hereby amended by inserting after paragraph (g) the following new paragraph (h):

*h. **Care Redesign Program.** The State shall implement a care redesign program in accordance with the terms of Appendix 9.*

5. Appendix 9. The Agreement is hereby amended to add the attached Appendix 9 immediately after Appendix 8. In the event of any inconsistency between the provisions of Appendix 9 and the provisions of the Agreement relative to the subject matter of Appendix 9, the provisions of Appendix 9 will prevail.

[SIGNATURE PAGE FOLLOWS]

Each party is signing this amendment on the date stated next to that party's signature. If a party signs this amendment, but fails to date a signature, the date that the other parties receive the signing party's signature will be deemed to be the date that such signing party signed this amendment.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Date: 5/1/17 By: 
Amy Bassano
Deputy Acting Director, Center for Medicare and Medicaid
Innovation


OFFICE OF THE GOVERNOR OF MARYLAND

Date: 4/27/17 By: 
Lawrence J. Hogan, Jr.
Governor

HEALTH SERVICES COST REVIEW COMMISSION

Date: 4/25/17 By: 
Nelson Sabatini
Chair

**DEPARTMENT OF HEALTH AND MENTAL
HYGIENE**

Date: 4/25/17 By: 
Dennis Schrader
Secretary

Attachment: Appendix 9

Appendix 9: Care Redesign Program

1. Definitions

The following terms have the meanings set forth below; capitalized terms not defined in this section have the meanings set forth in the CRP Participation Agreement.

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

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

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

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

“Care Partner List” means the list, as may be updated in accordance with section 5.2 of the CRP Participation Agreement, of Care Partners and Downstream Care Partners approved by CMS to participate in the CRP.

“Care Partner Qualifications” means additional criteria with which a Care Partner must comply in order to participate in a CRP Track and receive Incentive Payments, Interventions Resources, or both and with which a Downstream Care Partner must comply in order to participate in a CRP Track and receive Downstream Incentive Payments.

“CRP” stands for the “care redesign program” established by CMS and the State pursuant to this Appendix.

“CRP Beneficiary” means a Medicare FFS Beneficiary who either resides within the Service Area of the CRP Hospital or receives items or services at the CRP Hospital that incurs Episodic Costs.

“CRP Calendar” has the meaning set forth in section 2.j of this Appendix.

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

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

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

“CRP Performance Period” means the period of time when one or more CRP Tracks is in effect. The first CRP Performance Period will begin July 1, 2017 and end December 31, 2017. The second CRP Performance Period will begin January 1, 2018 and end December 31, 2018.

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

“CRP Report” means the report the CRP Hospital submits to the HSCRC and CMS, in accordance with section 9.1 of the CRP Participation Agreement.

“CRP Track” means a care redesign initiative developed by the HSCRC, the Department of Health and Mental Hygiene, and CMS and implemented by a CRP Hospital with the assistance of Care Partners.

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

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

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

“Episodic Costs” means Medicare Part A and Part B FFS expenditures that are associated with an episode of care that involves certain unique, specialized, or high cost Medicare covered items and services that are furnished by a CRP Hospital to CRP Beneficiaries. For purposes of this

definition, the HSCRC may designate as Episodic Costs a portion of costs incurred during an episode of care.

“FFS” stands for “fee for service.”

“Geographic Costs” means Medicare Part A and Part B FFS expenditures that are not Episodic Costs for Medicare covered items and services furnished to Maryland Medicare Beneficiaries who reside in the Service Area of the CRP Hospital.

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

“Incentive Payment Methodology” has the meaning set forth in section 4.a of this Appendix.

“Incentive Payment Pool” means the aggregate amount of Incentive Payments, as determined by the HSCRC in accordance with section 6 of this Appendix, that the CRP Hospital may pay to all of its Care Partners in a CRP Track for the relevant CRP Performance Period.

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

“Intervention Resource Allocation” means a monetary amount, as determined by the HSCRC in accordance with section 5 of this Appendix, that the CRP Hospital may use to fund Intervention Resources during a CRP Performance Period.

“Maryland Medicare Beneficiary” means a Medicare FFS Beneficiary who resides within the Service Area of any Regulated Maryland Hospital or receives items and services at a Regulated Maryland Hospital.

“Medicare FFS Beneficiary” means an individual enrolled in Medicare Part A or Part B.

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

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

“PAU Savings” means the Medicare cost savings the CRP Hospital is deemed to have achieved for a CRP Track through the reduction of PAU and other savings that the CRP Hospital achieved

as a result of the reduced PAU, as determined by the HSCRC in accordance with section 3 of this Appendix.

“**PGP**” stands for “physician group practice.”

“**PGP Member**” or “**Member of the PGP**” means a physician or NPP who is an owner or employee of a PGP or has entered into a contract with a PGP, and who has reassigned to the PGP his or her right to receive Medicare payment.

“**Service Area**” means the geographic area served by a CRP Hospital, as such area is defined pursuant to a written agreement between the CRP Hospital and the HSCRC governing the CRP Hospital’s global budget revenue or total budget revenue.

“**State Party**” means the Governor of Maryland, the Department of Health and Mental Hygiene, or the HSCRC.

“**TCOC**” stands for “total cost of care.”

“**TCOC Performance**” means the CRP Hospital’s average TCOC for Medicare FFS Beneficiaries who incurred either Geographic Costs or Episodic Costs at the CRP Hospital, as determined in accordance with section 7.c of this Appendix.

“**Track Implementation Protocol**” means a Track Implementation Template that has been approved by CMS in accordance with section 2 of this Appendix that is designed to be completed by the CRP Hospital and to set forth the CRP Hospital’s plan for implementing a CRP Track.

“**Track Implementation Template**” means the document in which the HSCRC sets forth the design and requirements for a CRP Track, including the information identified in section 2.c of this Appendix.

2. CRP Track Proposals and Amendments

- a. By the deadlines specified in the CRP Calendar, the HSCRC shall submit to CMS a Track Implementation Template for each CRP Track that the HSCRC wishes to implement for the first time. The HSCRC shall promptly submit to CMS any additional information that CMS determines is necessary to complete its review of the proposed Track Implementation Template, including amendments to the HSCRC’s CRP Monitoring Plan.
- b. If the HSCRC wishes to modify a CRP Track after it has been implemented, the HSCRC shall submit to CMS an amended Track Implementation Template no fewer than 120 days before the first day of the CRP Performance Period in which the CRP Track modifications would be implemented or by such other deadline as

may be specified by CMS. The HSCRC shall promptly submit to CMS any additional information that CMS determines is necessary to complete its review of the amended Track Implementation Template, including amendments to the HSCRC's CRP Monitoring Plan. CRP Track modifications must become effective on the first day of the relevant CRP Performance Period, except as may be required pursuant to section 12.b.vi.

- c. A Track Implementation Template must include at least the following information:
 - i. A list of available CRP Interventions;
 - ii. The methodology that will be used by the HSCRC to calculate PAU Savings and that complies with section 3 of this Appendix;
 - iii. The methodology that must be used by the CRP Hospital to calculate Incentive Payments and that complies with section 4 of this Appendix;
 - iv. Care Partner Qualifications, if applicable; and,
 - v. Instructions requiring each CRP Hospital to –
 - A. Determine the amount and nature of Intervention Resources provided to a Care Partner in a manner substantially based on criteria related to quality of care and the performance of Allowable CRP Interventions, consistent with section 6.5.f of the CRP Participation Agreement;
 - B. Specify the Intervention Resources it proposes to distribute to Care Partners during the upcoming CRP Performance Period;
 - C. Identify the cost of each Intervention Resource based on the CRP Hospital's actual costs for the Intervention Resource or a reasonable estimate of such costs, provided that such actual or estimated costs are consistent with general market value; and
 - D. Select Care Partners in accordance with written care partner selection criteria that satisfy section 6.2. of the CRP

Participation Agreement and to identify such criteria in completing the Track Implementation Protocol.

- d. CMS shall accept or reject in writing each proposed or amended Track Implementation Template within 60 days of receipt. CMS will reject a proposed or amended Track Implementation Template that is incomplete or fails to comply with this Appendix. If CMS rejects an amended Track Implementation Template, the previously approved Track Implementation Template will remain effective unless CMS notifies the HSCRC otherwise.
- e. If CMS approves a proposed or amended Track Implementation Template, the HSCRC shall notify Regulated Maryland Hospitals that they may choose to implement the CRP Track in the upcoming CRP Performance Period.
- f. A Track Implementation Template that has been approved by CMS constitutes a “Track Implementation Protocol,” as defined in section 1 of this Appendix.
- g. The HSCRC shall make Track Implementation Protocols available to Regulated Maryland Hospitals that are interested in participating in the CRP.
- h. The HSCRC shall not permit any hospital to implement a CRP Track unless the hospital is a party to a CRP Participation Agreement that is in effect.
- i. The State shall administer the CRP in accordance with the terms of this Appendix and the CRP Participation Agreement.
- j. 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 any State Party.

3. PAU Savings Methodology

- a. The HSCRC shall determine PAU Savings for a CRP Performance Period in accordance with a methodology that satisfies the following criteria:
 - i. The methodology compares historical Medicare claims for a benchmark period against Medicare claims for the most recent 12 month period for which a 3 month claims run-out is available, and the benchmark period

must include one 12-month period immediately preceding the most recent 12-month period for which a 3 month claims run-out is available;

- ii. The methodology measures Medicare cost savings achieved by the CRP Hospital through the reduction of PAU and other savings that the CRP Hospital achieved as a result of the reduced PAU;
 - iii. 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
 - iv. If PAU Savings are attributed to a CRP Track, the same PAU Savings are not also attributed to a different CRP Track.
- b. The HSCRC shall calculate PAU Savings for each CRP Hospital using the PAU Savings methodology contained in the Approved Track Implementation Protocol for the relevant CRP Track.
 - c. The HSCRC shall notify each CRP Hospital of its PAU Savings for the relevant CRP Track and CRP Performance Period, as required under the CRP Participation Agreement.

4. Incentive Payment Methodology

- a. The HSCRC shall specify in its Track Implementation Template a methodology for calculating Incentive Payments and Downstream Incentive Payments (“**Incentive Payment Methodology**”) that satisfies the following criteria:
 - i. The methodology is substantially based on criteria related to quality of care and the performance of CRP Interventions and may take into account the amount of CRP Interventions performed by a Care Partner relative to other Care Partners;
 - ii. The methodology is applied separately for each individual or entity that qualifies for an Incentive Payment or Downstream Incentive Payment and does not result in an Incentive Payment or Downstream Incentive Payment that represents an average or weighted payment for CRP Interventions performed by multiple Care Partners or Downstream Care Partners; and

- iii. The methodology is not based on the volume or value of referrals of Federal health care program business furnished to patients who are not Maryland Medicare Beneficiaries.
- b. The HSCRC shall ensure that each CRP Hospital uses the Incentive Payment Methodology set forth in the relevant Approved Track Implementation Protocol, to calculate each Incentive Payment and Downstream Incentive Payment distributed to a Care Partner and Downstream Care Partner, respectively.

5. Intervention Resource Allocation

- a. The HSCRC shall require each CRP Hospital to specify in its Track Implementation Protocol the Intervention Resources it proposes to distribute to Care Partners and the cost of those Intervention Resources.
- b. If the HSCRC determines an Intervention Resource Allocation for a CRP Hospital, it shall make such determination based on the following:
 - i. The CRP Hospital's actual costs for each Intervention Resource, if known, or a reasonable estimate of such costs; and
 - ii. The portion of the CRP Hospital's Intervention Resource Allocation for the previous CRP Performance Period, if any, that was actually spent.
- c. The HSCRC may deny funding, in whole or in part, for one or more Intervention Resources specified in the Track Implementation Protocol completed by a CRP Hospital.
- d. The HSCRC shall include each CRP Hospital's Intervention Resource Allocation, if any, for the relevant CRP Track and CRP Performance Period in the CRP Hospital's relevant Approved Track Implementation Protocol.

6. Incentive Payment Pool

- a. The HSCRC shall determine each CRP Hospital's Incentive Payment Pool for a CRP Performance Period by calculating the amount by which PAU Savings achieved by the CRP Hospital for the relevant CRP Track exceeds the Intervention Resource Allocation, if any, for that CRP Track.
- b. The HSCRC shall calculate PAU Savings using the PAU Savings methodology contained in the CMS approved Track Implementation Template for the relevant

CRP Track, which must also be set forth in the CRP Hospital's Approved Track Implementation Protocol.

- c. The HSCRC shall notify each CRP Hospital of its Incentive Payment Pool, if any, for the relevant CRP Track and CRP Performance Period as required under the CRP Participation Agreement.
- d. If the HSCRC learns that an Incentive Payment Pool determination was calculated incorrectly, it shall notify CMS promptly.

7. Total Cost of Care

- a. TCOC Guardrail. The HSCRC shall not permit a CRP Hospital to distribute any Incentive Payments to Care Partners for a CRP Performance Period or any portion thereof unless the CRP Hospital's recent TCOC Performance (as determined in accordance with section 7.c of this Appendix) is less than the CRP Hospital's TCOC benchmark (as determined in accordance with section 7.b of this Appendix).
 - i. The HSCRC shall calculate each CRP Hospital's recent TCOC Performance and TCOC benchmark no later than 90 days after the start of the CRP Performance Period for which the relevant Incentive Payments will be made.
 - ii. The HSCRC shall inform each CRP Hospital of its recent TCOC Performance relative to its TCOC benchmark as required by the CRP Participation Agreement.
- b. TCOC Benchmark. The HSCRC shall calculate a CRP Hospital's TCOC benchmark using the formula $[A/B] * [1 + \text{TCOC Trend Factor}]$, where –
 - i. "A" is the sum of the CRP Hospital's total Geographic Costs and total Episodic Costs for the 12-month period immediately preceding the most recent 12-month period for which a 3-month claims run-out is available;
 - ii. "B" is the total number of CRP Beneficiaries whose Geographic Costs or Episodic Costs are included in "A"; and
 - iii. "TCOC Trend Factor" is determined in accordance with section 7.d of this Appendix.
- c. Recent TCOC Performance. The HSCRC shall calculate a CRP Hospital's recent TCOC Performance by dividing "C" by "D," where "C" is the sum of the CRP Hospital's total Geographic Costs and total Episodic Costs for the most recent 12-

month period for which a 3-month claims run-out is available, and “D” is the total number of CRP Beneficiaries whose Geographic Costs or Episodic Costs are included in “C.”

d. TCOC Trend Factor

i. By the deadlines specified in the CRP Calendar, the HSCRC shall propose to CMS a TCOC Trend Factor for each CRP Performance Period, applicable to all CRP Hospitals for all CRP Tracks.

ii. The TCOC Trend Factor must take into account the State’s obligation to remain on target to --

A. Achieve the Medicare per beneficiary hospital savings target set forth in section 8.b.i of the Agreement; or

B. Avoid a Triggering Event under section 14.c.ii-v of the Agreement.

iii. CMS shall review the HSCRC’s proposed TCOC Trend Factor within 30 days of receipt and either approve the TCOC Trend Factor or request revisions to it. If CMS requests revisions to the proposed TCOC Trend Factor, the HSCRC shall submit a revised TCOC Trend Factor to CMS within 30 days. CMS shall notify the HSCRC within 45 days of receipt if the revisions have been rejected; if CMS fails to provide such notice, the revisions are deemed approved.

e. Determination of Episodic Costs. By the deadlines specified in the CRP Calendar, the HSCRC shall submit to CMS a proposed list of Episodic Costs for each CRP Performance Period. CMS shall review the list within 30 days of receipt and either approve the list or request revisions. If CMS requests revisions to the list, the HSCRC shall submit a revised list to CMS within 30 days. CMS shall notify the HSCRC within 30 days of receipt if the revisions have been rejected; if CMS fails to provide such notice, the revisions are deemed approved.

8. Interaction with Other Medicare Initiatives. CMS may amend this Appendix without the consent of any State Party as may be necessary to avoid duplicative accounting for items or services furnished by a provider, supplier, or any other participant in an existing or future Medicare program, demonstration, or model other than the CRP. CMS shall provide at least 90 days written notice of any such amendment.

9. Monitoring the CRP

- a. By the deadlines specified in the CRP Calendar, the HSCRC shall develop and submit to CMS a CRP Monitoring Plan, which shall include provisions regarding review of CRP Reports to determine CRP Hospital compliance with relevant Approved Track Implementation Protocols and periodic reporting to CMS regarding its monitoring activities.
- b. The CRP Monitoring Plan shall specify that the HSCRC shall ensure that each CRP Hospital has, upon submission of a CRP Report, certified the following:
 - i. That the CRP Report is true, accurate, and complete; and
 - ii. That if the CRP Hospital learns that a submitted CRP Report is not true, accurate, or complete, it will promptly submit a revised CRP Report.
- c. If the HSCRC amends its CRP Monitoring Plan (as may be required under section 2 of this Appendix) or otherwise modifies its CRP Monitoring Plan, it shall submit the revised CRP Monitoring Plan to CMS for review.
- d. CMS shall review the CRP Monitoring Plan within 30 days of receipt and shall either approve the plan or request revisions. If CMS requests revisions to the plan, the HSCRC shall submit a revised plan to CMS within 30 days. CMS shall review the revisions within 30 days of receipt and either approve or reject it. The HSCRC shall not implement a CRP Monitoring Plan, including a revised CRP Monitoring Plan that has not been approved by CMS. The HSCRC shall monitor the CRP in accordance with the CRP Monitoring Plan most recently approved by CMS.
- e. The HSCRC shall submit to CMS a report on the HSCRC's monitoring activities and its implementation of its CRP Monitoring Plan ("**CRP Monitoring Report**") by the deadlines specified in the CRP Calendar.
- f. In addition to the requirements of section 9 of this Appendix, the State and CMS shall continue to monitor the Model in accordance with section 12 of the Agreement.
- g. The HSCRC shall promptly notify CMS in writing if it has failed to comply with any of the terms of this Appendix 9, or if it becomes aware as a result of its monitoring activities or through other means, that a CRP Hospital failed to comply with any of the terms of the CRP Participation Agreement. Such notice shall specify the noncompliance, the relevant facts, and in the case of a CRP

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

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

10. Evaluation of the CRP

- a. In evaluating the Model in accordance with section 11.a of the Agreement, CMS shall assess the impact and effectiveness of the CRP. The State and its agents shall cooperate in such evaluation, as set forth in section 11.a of the Agreement.
- b. The State shall continue to conduct its evaluation of the Model in accordance with section 11.b of the Agreement. No later than December 31, 2017, the State shall amend Appendix 7 of the Agreement to include additional evaluation data and measures regarding the CRP in consultation with CMS.

11. Record Retention. The State shall maintain records regarding the CRP in accordance with section 12.c of the Agreement.

12. Remedial Action under the CRP

- a. Grounds for Remedial Action. CMS may impose remedial action against a State Party if CMS makes a determination that one or more State Parties:
 - i. Has failed to comply with any of the terms of this Appendix or the CRP Participation Agreement;
 - ii. Has failed to demonstrate improved performance following any remedial action, including a CAP;
 - iii. Has taken any action that threatens the health or safety of a Medicare FFS beneficiary or other patient; or
 - iv. Has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the CRP or the Model.
- b. Types of Remedial Action. If CMS determines that remedial action is warranted pursuant to section 12.a of this Appendix, it shall issue a written notice to each State Party specifying the grounds for remedial action, the relevant facts, and the

remedial action being imposed. CMS may impose one or more of the following remedial actions:

- i. Require one or more State Parties to provide additional information to CMS;
- ii. Subject one or more State Parties to additional monitoring, auditing, or both;
- iii. Require the HSCRC to recalculate the PAU Savings or the Incentive Payment Pool for a CRP Hospital;
- iv. Require the HSCRC to adjust an Intervention Resource Allocation for a CRP Hospital;
- v. Require the HSCRC to require a CRP Hospital to revise and resubmit to CMS, or to terminate, one or more of a CRP Hospital's Approved Track Implementation Protocols;
- vi. Require the HSCRC to amend one or more of its Track Implementation Templates;
- vii. Require the HSCRC to terminate one or more of the CRP Tracks; or
- viii. Require the HSCRC to propose a CAP and implement such CAP after CMS approval.

13. Termination of the CRP

a. Automatic Termination

- i. The CRP terminates upon the effective date of the termination of a CRP Track if such track is the only CRP Track available under the CRP.
- ii. The CRP terminates if CMS fails to approve a Track Implementation Template by the start of a CRP Performance Period if such template pertains to the only CRP Track available under the CRP for that CRP Performance Period.

- b. Termination by the State. The State may terminate the CRP upon 3 months advance written notice to CMS.
 - c. Termination by CMS. CMS may immediately or with advance notice terminate the CRP if CMS determines that any of the grounds for remedial action set forth in section 12.a of this Appendix continue to exist after remedial action has been taken.
- 14. Survival.** Termination of the CRP shall not affect the rights and obligations of the parties accrued under the Agreement or this Appendix prior to the effective date of termination or expiration of the CRP, including obligations regarding submission of reports and other data, record retention under section 12.c of the Agreement, monitoring and evaluation activities, and cooperation with monitoring and evaluation activities.
- 15. HSCRC Agents.** The HSCRC may designate a Maryland agency, committee or commission, or a non-governmental organization, to carry out the obligations of the HSCRC as specified in this Appendix. The HSCRC will remain responsible for its obligations regardless of any such designation.