

Maryland Medicare Total Cost of Care Model Terms

HSCRC STAFF SUMMARY

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Vision and Goals

Vision

Achieve person-centered care, foster clinical innovation and excellence in care, improve population health, and moderate the growth in costs, on a statewide basis and in the all-payer environment through the transformation of the health care delivery system.

Maryland plans to achieve its vision by working toward three key goals:

- (1) Improve population health;
- (2) Improve outcomes for individuals; and
- (3) Control growth of total cost of care.

A critical next step: Statewide innovation beyond hospitals, through their partnership with providers, facilities, payers, and State agencies, to accomplish system-wide goals under the Total Cost of Care (TCOC) Model.

TCOC Model at a Glance:

- The new Total Cost of Care Model will begin on January 1, 2019 for a 10-year term, so long as Maryland meets the model performance requirements.
- Hospital cost growth per capita for all payers must not exceed 3.58% per year. The State has the opportunity to adjust this growth limit based on economic conditions, subject to federal review and approval.
- Maryland commits to saving \$300 million in annual total Medicare spending for Medicare Part A and Part B by the end of 2023.
- Resources that are consistent with national and State goals to improve chronic care and population health will be invested in primary care and delivery system innovations.
- The Model will help physicians and other providers leverage voluntary initiatives, federal programs, and incentive programs to align participation in efforts focused on improving care and care coordination. These programs will be voluntary and the State will not undertake setting Medicare and private fee schedules for physicians and clinicians.
- Maryland will set aggressive quality of care goals.
- Maryland will set a range of population health goals.

Goals

Goal 1: Improve population health

- Ensure adequate access to appropriate community-based care to promote prevention and early detection of disease.
- Identify and provide additional resources (e.g., increased access to care and team-based supports, effective coordinated treatment, medication management, behavioral health services, and other services) for individuals with complex and chronic conditions to slow disease progression.
- Address upstream influences on health status, including personal health behaviors, behavioral health issues, and environmental factors particularly for vulnerable populations.

- Address social determinants of health status and access to care through case management, resources from community organizations, and public health focus and supports.

Goal 2: Improve care outcomes for individuals

- Enhance the delivery system’s person-centered care approach. This approach tailors care to individual needs and goals, engages patients and families in decision-making, and educates patients and caregivers on appropriate care and recovery.
- Improve episodes of care, reaching beyond individual events. Person-centered care uses state-of-the-art health information tools to make better information available at the point-of-care and to coordinate care across the system.
- Increase supports for complex and chronically ill patients to enable them to manage their conditions effectively in order to prevent avoidable utilization and complications of disease.
- Encourage appropriate use of community-based services so that individuals with complex and chronic health issues, including behavioral health issues, can continue living and receiving care in the community.
- Improve coordination of care across settings, reducing re-visits and medication errors, and improving outcomes.
- Reduce conditions acquired in health care facilities and complications of care.

Goal 3: Control growth of total cost of care

- Strive to achieve the first two goals (i.e., improving population health and improving care outcomes) because the most effective strategy for reducing the need for high-cost settings and interventions is to keep people healthy and well supported in the community.
- Provide an early and intense focus on fee-for-service (FFS) Medicare and dual eligible beneficiaries, since these populations are rapidly growing, have higher needs, and underdeveloped supports.
- Transform and align payment and delivery systems around the core goals of improving outcomes and health, and thereby supporting high-value care in appropriate settings.
- Support all provider types in organizing to take increasing accountability for cost and care outcomes.
- Align public health and community organizations to provide chronic illness management supports that enable vulnerable individuals and their families to function safely in their homes and in the community.

Model Duration

Start Date

In this term sheet, the All-Payer Model in effect from 2013 through 2018 is referred to as the “base model.” The new successor All-Payer Model, which has been enhanced to incorporate Medicare Total Cost of Care, is referred to as the “Total Cost of Care All-Payer Model,” “TCOC Model,” or “Model.” The TCOC All-Payer Model will begin on January 1, 2019.

Life of Model and Opportunity to Extend

The TCOC Model will begin on January 1st, 2019 and continue for 10 years, so long as Maryland meets the requirements of the Agreement.

By the end of 2023 (PY 5), the fifth year of the 10-year term, Maryland will commit to reaching a compounded annual Medicare savings target relative to the national Medicare total cost of care trend from the 2013 base year.

Prior to the end of 2022 (PY 4), the Centers for Medicare and Medicaid Services (CMS) and Maryland will assess Model progress and determine if savings are on track to meet the savings target. By the end of 2023 (PY 5), Maryland and CMS will agree on a formula to determine the maximum allowable Medicare total cost of care growth rate for the second 5-year period of the TCOC Model. This growth rate will ensure that the compounded annual payment growth in Maryland is no greater than the national average growth over a period to be determined (e.g. two-year cycle with corrections from estimates to actual, three-year rolling average period). A rolling average would assure CMS of ongoing limits in the growth per beneficiary, while addressing normal variation that can occur on a year-to-year basis.

- If Maryland has not met its PY 5 savings target, then the additional savings requirement, net of any portion already adjusted for through the application of the Medicare Performance Adjustment, will be considered in the development of the allowed growth rate.
- If CMS and Maryland cannot agree to a growth calculation, CMS will set the growth limit by adding \$36 million to the PY 5 savings target of \$300 million. An additional \$36 million will continue to be added to PYs 7 and 8 to maintain the achieved savings level prior to returning the Maryland system to CMS national programs.

In January 2024 (PY 6) or sooner, CMS will consider whether to expand the Model (i.e., make the Model an ongoing Model and test whether Maryland can meet a national average growth rate test, without a specific duration). CMS will inform Maryland of its decision by no later than December 31, 2024.

- If the Model is expanded, CMS will draft regulations to make other changes and agreements needed by January 2027 to accomplish this outcome and for implementation no later than January 2029.
- If the Model is not expanded, CMS will consider Maryland's proposal for a new Model, which will be submitted to CMS no later than January 1, 2026 (PY 8). By December 31, 2026, CMS will approve or reject Maryland's proposal for a new Model. If CMS rejects Maryland's proposal, then Maryland's Medicare hospital payment system will begin the transition to a CMS system over a two-year timeframe, subject to the provisions described in the "Severability, Corrective Action, and Termination" section of the TCOC Agreement.

Beginning in 2019 (PY 1), CMS and Maryland will assess the level of care management fees and other primary care or Medicare investments calculated in the total cost of care. Maryland will offset primary care or other approved investment costs with warranted population health savings or credits, which will be determined annually from throughout the term of the Model.

Model Progression and Milestones

To create alignment between Medicare and the goals of the TCOC Model, Maryland will systematically align payment and delivery for selected Medicaid beneficiaries, particularly those who are dually eligible for Medicare and Medicaid, or are not under managed care models. Alignment will progress to incorporate an accountability approach for dual-eligible Marylanders, such as Medicaid total cost of care responsibility and Long Term Support Services (LTSS) integration by 2021 (PY 3). National models could

be adopted and modified to meet State needs as providers and Maryland gain experience with service delivery under the models thereafter.

Model Tests

Hospital Financial Tests – Per Capita Limits

- The all-payer growth limit for hospital costs, which was set in 2014 based on the long-term growth in per capita gross state product, will continue to be set at 3.58% on an annual basis, measured on a cumulative basis from 2013 through the term of the Agreement. The all-payer trend cap is a ceiling and not a floor. There will continue to be opportunities for reductions to the trend based on policies related to utilization, efficiency, or other factors adopted by the HSCRC.
- HSCRC will have the discretion to review and adjust the overall 3.58% cap, based on future economic growth trends or other factors and subject to prior approval by CMS.
- The all-payer hospital growth will continue to be measured against the 2013 base year and the results relative to the limit will be measured annually and cumulatively.

Five-Year Medicare Savings

- The Medicare per beneficiary total spending (Parts A and B) target will be set to build to \$300 million in annual savings, relative to the 2013 base year, by the end of 2023 (PY 5) of the TCOC Model. Interim targets beginning 2019 through 2023 relative to the 2013 base year will lead to the fifth-year savings target.
- Medicare savings will be calculated by first establishing a baseline that is the actual Medicare per beneficiary total expenditures in Maryland in 2013 trended forward by the national average growth rate in Medicare per beneficiary total expenditures to each year of the Model. Then, the savings calculation will compare Maryland's annual Medicare per beneficiary total expenditures to that baseline.
- Regardless of the changes in the national trend over the course of the Model, Maryland will be expected to reach a compounded annual savings level of \$300 million progressively over five years, beginning in 2019, to be calculated in the manner described above.
 - If Maryland fails to meet an annual progression target, the annual percentages to meet the final 2023 target will be adjusted prospectively. If Maryland fails to meet the target progression target by \$100 million or more, then Maryland will need to submit a corrective action plan as described in the "Severability, Corrective Action and Early Termination" section of the TCOC Agreement.
 - If there are delays in federal deliverables under the agreement, Maryland will be permitted to extend the savings progression to permit sufficient time to achieve the PY 5 savings goal beyond 2023.
- CMS agrees to operationalize the use of the Medicare Performance Adjustment with the potential to apply a discount to Medicare payments, if the HSCRC deems it necessary. This mechanism must be available no later than January 1, 2019.
- Savings performance will be adversely affected by exogenous factors, including changes in insurance coverage under the Affordable Care Act. CMS and Maryland will take this into account in evaluating performance and in revising savings targets if necessary.

- Since Medicare Advantage plans’ rates are set in reference to FFS performance, changes in Medicare Advantage enrollment will affect the accumulation of savings. To account for this effect, the FFS savings will be extrapolated based on the Medicare Advantage enrollment.
- Non-fee schedule payments will be included in costs for both Maryland and non-Maryland national payments, except as otherwise agreed.
- If there are excess Medicare savings from the targets during Model PYs 1 and 2, half of the total excess savings will be credited towards the following year’s the total cost of care savings calculation. The other half of excess savings would accrue to Medicare. This is intended to incentivize early savings above the projected 2018 savings.

Medicare Savings Targets

The final compounded annual Medicare TCOC savings target relative to the 2013 base is \$300 million at the end of 2023 (PY 5).

		Compounded Medicare TCOC Savings Target	Annual Medicare TCOC Savings Increment
2019	PY 1:	\$120 million	(\$0 increment)
2020	PY 2:	\$156 million	(\$36m increment)
2021	PY 3:	\$222 million	(\$66m increment)
2022	PY 4:	\$267 million	(\$45m increment)
2023	PY 5:	\$300 million	(\$33m increment)

Based on current savings requirements of the base model, this is estimated to result in cumulative program savings outlined below:

		Estimated cumulative savings to Medicare
2018	Base Model:	\$599 million
2019	PY 1:	\$719 million
2020	PY 2:	\$875 million
2021	PY 3:	\$1.0972 billion
2022	PY 4:	\$1.364 billion
2023	PY 5:	\$1.664 billion
	Less Base Model:	(\$599 million)
	Net TCOC Model:	\$1.060 billion

Maryland Primary Care Program (MDPCP)

The Maryland Primary Care Program will be implemented at the beginning of 2019 (Model Year 1) through 2026 (MY 8), unless otherwise modified. CMS will accept applications from primary care practices and Care Transformation Organizations (CTOs) for participation in the MDPCP on an annual basis through MY5 (2023). Practices and CTOs that are eligible to participate in the MDPCP must sign an MDPCP Participation Agreement with CMS in order to enroll.

- CMS will make two prospective payments, on a PBPM basis for attributed Medicare FFS beneficiaries, to all providers enrolled in the MDPCP for the duration of the qualified provider’s term in the MDPCP.

- The payments will include a risk-stratified monthly care management fee for practices by Track, ranging from \$6-\$50 PBPM (Track 1) and \$9-\$100 PBPM (Track 2).
- MDPCP payments will include an at-risk performance bonus ranging from \$2.50 PBPM (Track 1) to \$4.00 PBPM (Track 2). The performance bonus may be clawed back by CMS based on a provider's performance against established quality, patient satisfaction and utilization benchmarks.
- For the CTOs, there will be an at-risk performance bonus of \$4.00 PBPM based on population health measures and quality.
- The Performance bonuses and several other financial aspects of the program are considered non fee schedule payments, including the care management fees, performance bonus, MACRA bonus and the Learning System, and are thus included in total cost of care calculations.
- Maryland and CMS anticipate that one or more payers with a well-developed Patient Centered Medical Home Model and tools will participate in the Maryland Primary Care Program either as strategically aligned as commercial payers or as CTOs. Payers will also participate with aligned payment, utilization and quality programs with the participating practices. Patient experience and utilization measures that will be adjusted annually.
- The annual costs of MDPCP payments will be considered in MYs 1 through 10, as discussed above in the Life of the Model and Opportunity to Extend section above. Maryland will offset primary care or other approved investment costs with warranted population health savings and improvement credits, which will be determined annually through MY 10 of the Model.
- The cost of investments will be considered in evaluating the overall performance of the TCOC Model and the MDPCP program in determining the ongoing progression of the Model, and beyond, and when performing required evaluations of cost and quality.
- The MDPCP, as a component of the TCOC Model which is qualified as an Advanced Alternative Payment Model under the CMS Quality Payment Program, may provide a pathway for eligible MDPCP participants to become Qualifying APM Participants (QPs), so long as they meet the requirements. Providers who do not receive an at-risk performance bonus due to their participation in another CMS model will need to qualify as a QP under a different program.
- Medicare and Medicaid physician cost data should not be the basis of physician reimbursement or allocation of shared savings to physicians in the MDPCP, in the event that the program evolves to include non-Medicare or non-Medicaid beneficiaries.

Quality and Value-Based Metrics

- Maryland will be waived from the CMS Value-Based Purchasing (VBP), Hospital Acquired Conditions, and Readmissions programs, but will continue to run comparable quality programs applied on an all-payer basis. If CMS finds the Maryland value-based programs are not achieving performance improvement, Maryland will have the opportunity to submit a corrective action plan, following the same timelines as those for overall model performance. At the end of this process, CMS will exercise its right to terminate Maryland's waiver from the CMS national program under 1886(p) of the Social Security Act.
- Maryland commits to reporting the same hospital quality measures reported by hospitals nationally under the IQR reporting program.
- The performance initiatives linked with payment under the Maryland all-payer system will be incorporated in the routine evaluation and reporting to CMS as part of the Model.

- Maryland will provide bold, annual performance targets and will report the performance against the targets, savings achieved, and linkage to payments. Maryland will also file an annual report documenting changes in its programs and demonstrating that its programs continue to meet or exceed the scope of the CMS programs.
- Maryland will develop and utilize population health measures as part of its portfolio of measures. Maryland will submit its plan for incorporating measures into its value-based hospital payment programs by March 31, 2019.

Quality Performance Programs

- Maryland will continue its current practice of increasing the percent of all-payer revenue at risk in VBP programs consistent with the Medicare percent revenue at risk in national programs. In its annual report to CMS, Maryland will include a description of how the quality and other value-based payment programs achieve or surpass the patient health outcomes and cost savings of the national programs.
- CMS encourages Maryland to utilize outcomes measures and recognizes that Maryland will utilize efficiency and outcome measures that are different from the nation, to align with TCOC Model goals.
- Maryland will work with CMS to ensure that Maryland is included in national measures in an accurate and appropriate manner.
- CMS will have the right to take appropriate corrective action, should Maryland fail to meet any of the above specified targets, including subjecting Maryland to the requirements of national programs.

Outcomes Based Credits

Maryland recognizes its responsibility to improve the health of the population. To this end, Maryland will direct its resources and activities to the extent possible to address a minimum of three population health priorities for Marylanders. Maryland will develop and propose to CMS for approval any time beginning 2019, the following for each population health priority:

1. Specifications for appropriate population health measures and applicable performance targets
2. Methodologies to assess Maryland's performance on each measure and target, relative to a comparison group or targeted level of improvement
3. Estimated savings to Medicare that could be expected due to State improvement on each measure and target

Maryland has already identified several potential focus areas in behavioral health (e.g., opioid deaths), chronic condition prevention and management (e.g., diabetes), and senior health and quality of life. These three areas may be used to focus care improvement activities and may be incorporated into value-based measures over time. Claims-based measures and survey data can be used to determine initial performance and to make value-based payments, while other measures from electronic medical records or comprehensive clinical data sources are brought to maturity.

Maryland may offset primary care or other approved investment costs with outcomes-based credits due to overall healthcare savings that can be ascribed to the improvements in the selected measures. Maryland's annually proposed credits to be applied to Annual Medicare Savings must

correspond to at least one population health measure and target. For each measure, the proposal must be submitted to CMS with all data, programs, and documentation of Maryland's performance against the performance target as well as the estimated savings to Medicare due to Maryland's performance compared with that performance target. CMS will annually determine the credits awarded to Maryland through MY 8.

Calculation Considerations

ACO

CMS and Maryland will monitor the interaction of ACOs with the All-Payer and TCOC Models. CMS and Maryland anticipate that ACOs will contribute to meeting the performance requirements of the Models.

Shared savings payments will be added to the total cost of care in both Maryland and national expenditures in determining the Medicare savings. If CMS and Maryland determine that shared savings payments adversely affect the ability to meet the savings requirements of the Models, CMS will make future adjustments to trend factors or benchmarks used for ACOs to ensure consistency with the Medicare savings requirements.

Maryland and CMS acknowledge that the Medicare Performance Adjustment and the ACO models can act as reinforcing mechanisms. Maryland will work with CMS to determine how to attribute costs from non-claims based payments, as needed, to beneficiaries in order to support cost findings for ACOs, hospital savings, geographic models, and other payment models. If administered through a discount or premium, the Medicare Performance Adjustment will be recognized as a cost reflected in fee-for-service claims payment, and, therefore, not double counted.

Non-fee schedule payments made by CMS will be counted as expenditures in both Maryland and non-Maryland settings, except as otherwise agreed.

Public - Private Payer Differential

- CMS and Maryland expect that the targets established under the All-Payer Model are achievable without any change in the hospital differential. However, if hospital expenditures are lower than the all-payer cap, but Medicare TCOC savings are not sufficient, a differential will be used in the TCOC Model to assure the required savings.
- Additionally, Maryland will request a change in the differential to effectuate changes in overhead allocations or other factors used in the rate-setting system that will be necessary to adjust and modernize the rate-setting structure while avoiding cost-shifting.
- To ensure that the differential is only used in a manner consistent with the terms of the Agreement, CMS must review and approve any change in the differential prior to its implementation. CMS will make an effort to respond to a request within 120 days of receiving such a request.

Per Beneficiary Expenditure Calculation and Adjustments to Savings Calculations

- Medicare spending per beneficiary, along with data from other sources as necessary, will be used in calculating savings.
- The Medicare spending will be calculated with two fractions – Medicare per beneficiary Part A costs and per beneficiary Part B costs. These two fractions will be added to determine the Medicare per beneficiary total cost.

- This calculation will be done for Medicare fee-for-service beneficiaries.
- The growth in Maryland per beneficiary total cost will be compared to the national growth rate in per beneficiary total cost.
- The per-beneficiary total cost calculation for Maryland will include all provider expenditures, regardless of Maryland of service.
- The calculation will be based on Medicare's definition of total costs specified in the contract.
- Non-fee schedule payments made by CMS will be counted as expenditures in both Maryland and non-Maryland settings.
- Savings will be extrapolated to incorporate the expected impact on Medicare Advantage payments.
- Maryland will work with CMS to determine how to attribute costs as needed, to beneficiaries to support cost findings for ACOs, hospital savings, geographic models, and other payment models.
- Maryland and CMS acknowledge that the Medicare Performance Adjustment and the ACO models can act as reinforcing mechanisms. When there is significant overlap in savings, such as a geographic performance model, CMS and Maryland will need to determine how to adjust for the overlap in savings. The Medicare Performance Adjustment will be recognized as a cost reflected in FFS claims payment and therefore not double counted.
- Maryland and CMS will continue to calculate hospital savings and recognizes that investments will be made in non-hospital settings to produce hospital savings. This effort will support adding and eliminating components as needed, based on their performance.

Payment and Delivery System Transformation & Supporting Tools

Population-Based Revenue

Maryland will use a population-based model for hospital reimbursement. A population-based model refers to a model of hospital reimbursement that is either “directly population-based” (i.e., tying hospitals' reimbursement to the projected services of a specific population or specific residents) or one that establishes a fixed global budget for hospitals for services connected through an attributed population of patients.

For care redesign programs beyond hospitals, Maryland will seek to design programs that would be available to multiple payers, if they choose to participate. Although, in some instances, initial implementation will be focused on Medicare, aligned efforts can serve to support transformation goals and to increase effectiveness and reduce administrative burden for providers and payers.

Medicare Performance Adjustment

- HSCRC will utilize a Medicare Performance Adjustment (MPA), which incorporates attribution, episodes and/or geographic measures of total cost of care for Medicare into hospital value-based payments. This will provide a level of direct hospital accountability within the All-Payer Model for total cost of care and support the process of aligning physicians within the TCOC Model.
- For calendar year (CY) 2018, the revenue-at-risk under the MPA will be 0.5% of Medicare hospital revenues. For CY 2019, the revenue-at-risk will be 1% of Medicare hospital revenues.

The HSCRC will determine the need to increase the revenue-at-risk in the succeeding years based on performance and other factors.

- The HSCRC will administer the MPA through a discount mechanism, subject to CMS’s review of the associated calculations and specifications under a timeline to be specified in the Care Redesign Program calendar. Maryland and CMS will need to develop an operational plan that will allow for the application of discounts and premiums with its fiscal intermediaries.
- Maryland will also submit proposals for efficiency adjustments through the MPA. This will allow statewide or program-specific adjustments to be made based on established methodologies approved by CMS.
- In order to conform with MACRA requirements for quality performance payment, MPAs will be increased or reduced by multiplying the adjustment by each hospital’s revenue adjustment percentages for the all-cause readmissions and hospital acquired conditions quality programs. Positive MPAs will be increased and negative MPAs will be reduced for positive quality adjustments. Conversely, negative MPAs will be increased or positive MPAs will be reduced for negative quality adjustments.
 - Maryland and CMS acknowledge that the MPA and the ACO models can act as reinforcing mechanisms. When there is significant overlap in savings, CMS and Maryland will need to determine the approach to adjust for the overlap. To the extent that the MPA is recognized in FFS claims payments and therefore recorded as a cost or cost recovery, the issue of overlap is a timing and policy issue.
- Because the TCOC Model is classified as an Advanced Alternative Payment Model (“Advanced APM”) under CMS’ Quality Payment Program, hospitals with Global Revenue Agreements and the Medicare Performance Adjustment are classified as Advanced APM entities under the TCOC Model. CMS and Maryland will make amendments as needed to the Model to ensure that it continues to meet the requirements of an Advanced APM.
- After 2019, Maryland will submit a request to CMS to introduce an MPA for non-hospital providers, which will also incorporate population health targets. The modifier could be applied to voluntary participants in the Care Redesign Program that have a direct relationship with CMS and Maryland through a Participation Agreement. CMS will accept, modify, or reject the proposal.

Care Redesign Program

- CMS and Maryland will work to develop care redesign components of the TCOC Model that further Model goals and foster alignment across the delivery system. These components can be initiated as new Tracks under Maryland’s existing Care Redesign Program (CRP), or as New Model Programs (discussed in subsequent section).
- Maryland will seek input from and collaboration with care partners, including but not limited to physicians, hospitals, long-term care providers, post-acute providers, and insurers, during the development of voluntary care redesign programs, as appropriate. Maryland will also seek partnership with payers as appropriate.
- To bind participants in the Care Redesign Program to the TCOC Model provisions, participants will sign a Participation Agreement with Maryland of Maryland and CMS. Participation agreements will include applicable waivers and data.

- Total Cost of Care guardrails applicable to incentive payments under Care Redesign Program will be replaced with the Medicare Performance Adjustment as the tool to ensure that care redesign participants will be attentive to the total cost of care performance when designing and implementing care redesign interventions.
- The TCOC Model will include opportunities to deploy Medicare waivers to support care redesign. After 2019, Maryland may request additional waivers for CRP Tracks or New Model Programs, which must be filed with CMS according to the Care Redesign Calendar. If needed, Maryland and CMS will amend Participation Agreements.
 - Medicare and Medicaid physician payment data will not be the basis for design of a new CRP Track for private payers or allocation of shared savings to physicians in a care redesign program that treats non-Medicare or non-Medicaid beneficiaries. In evaluating the voluntary programs and performance for private patients that will be proposed, Maryland will access and use independent data bases for services beyond hospital services that contain claims for private payers.
 - Maryland will avoid the use of Medicare and Medicaid payments and service utilization to develop benchmarks or design programs for private patients or payers.
 - Maryland will not set physician fee schedules for private payer or Medicare payments under the TCOC Model Agreement. Should consequences of compliance with the TCOC Model negatively impact, in any way, rates of physician compensation in contracts with physicians, then CMS will evaluate the impact of the Model and will require changes to the Agreement to address the impact.

MACRA Eligibility

CMS and Maryland intend for the TCOC Model to be classified as an Advanced APM, and regulated hospitals under Global Revenue agreements with Medicare Performance Adjustment requirements to be qualified as Advanced APM Entities in CY 2018. CMS and Maryland will amend the Model to assure continued MACRA qualification beyond 2019. CMS and Maryland will work together to ensure that Care Redesign or other programs (e.g., Maryland Primary Care Program) are available to allow physicians and other clinicians to participate in the TCOC Model. CMS and Maryland will make amendments as needed to the Model to ensure that it meets the requirements of an Advanced Alternative Payment Model under QPP.

Proposals for New Model Programs

During the Performance Period of the Model, Maryland will submit to CMS a proposal for a new Model Program or for modifications to an existing Model Program (i.e., the Hospital Payment Program, CRP, and the MDPCP. CMS will make reasonable efforts to approve or reject Maryland's New Model Program Proposal within 180 days of receipt. All New Model Programs or requested modifications to existing Model Programs will need to enhance Maryland's ability to meet the population health outcomes and measures and targets and overall TCOC Model goals.

In developing the Model Program Proposal, the Maryland will collaborate with Care Partners and other stakeholders, including but not limited to physicians, hospitals, long-term care providers, post-acute care providers, behavioral health providers, and Maryland Payers, as appropriate, to ensure input into the new or modified Model Program.

New Model Program proposals will need to include operational plans, including any waivers needed, impacts on total cost of care per beneficiary growth rate, key stakeholder perspectives, plans for encouraging participation, and a monitoring/evaluation strategy. New Model Program proposals could include one or more of the following:

- Payment for Alcohol and Substance Use Disorder
- Non-Hospital Performance Adjustment
- Alignment with Medicaid

New Model Program proposals will maintain voluntary participation by and alignment with private payers. Maryland will not set physician fee schedules for private payers or Medicare. Medicare and Medicaid physician payment data will not be the basis for the design of any new Model program for private payers or for allocation of shared savings to physicians in a new Model Program that would affect payments for services furnished to only non-Medicare or non-Medicaid beneficiaries. Maryland will reference independent databases, when applicable, in working with private payers and other stakeholders in the design of Model Programs that involve alignment with private payers.

Post-Acute and LTSS Proposal

Maryland will submit to CMS a proposal for a payment and delivery system transformation that includes post-acute care and long-term services and supports by no later than January 1, 2021. The Post-Acute and LTSS Proposal must include a plan for progressively increasing Maryland's accountability for Maryland Medicaid beneficiaries' TCOC. CMS will review the Post-Acute and LTSS Proposal and decide whether to approve or reject the Post-Acute and LTSS Proposal.

Maryland Data

- CMS will make non-fee schedule payment data available on a timely basis.
- For non-fee schedule payments applicable to Maryland providers, CMS will provide sufficient details to allow cost allocations by beneficiary, which are needed to manage cost distributions for accountability under care redesign programs and TCOC model components.
- CMS will also provide data on payments made outside of Maryland to enable Maryland to account for the cost and cost growth for fee-for-service beneficiaries on a national basis. CMS will provide breakdowns by provider type and state to support more detailed efforts to benchmark costs and cost growth.

Waivers

- All waivers from the All-Payer Model, including those provided with the Care Redesign Amendment, will continue into the TCOC Model, including:
 - Continue OP facility waiver to allow for development of free-standing medical facilities and 340B programs.
 - Removing Medicare restrictions on reimbursement for licensed alcohol and drug abuse counselors and wrap around recovery services.
- Possible future Medicare rate setting authority for psych facilities.

Fraud and Abuse Waiver

- Financial arrangements between and among providers must comply with all applicable laws and regulations except as will be explicitly provided in a written waiver issued specifically for the All-Payer or TCOC Models pursuant to Section 1115A(d)(1) of the Social Security Act.
- The Secretary will consider issuing waivers of certain fraud and abuse provisions in Sections 1128A, 1128B, and 1877 of the SSA, as will be necessary solely for purposes of carrying out this model. Such waivers would be set forth in separately issued documentation specific to this model. Any such waiver would apply solely to this model and could differ in scope or design from waivers granted for other programs or models.
- Additional waivers will be provided by CMS with additional Care Redesign Program Tracks, new Participation Agreements, or other New Model Programs. There will be possible future Medicare rate-setting authority for psychiatric facilities.

Meaningful Use

Provisions in existing law related to meaningful use incentives and disincentives will continue to apply in Maryland.

Severability, Corrective Action, and Termination Triggers

Severability of Components

During the term of the agreement, Maryland will design, deploy, measure, refine and discontinue care design components as part of the model progression.

Failure of a component to meet its objectives will be subjected to a corrective action. The component will be terminated and other components of the TCOC Model will continue so long as they are meeting their performance requirements.

Termination and Corrective Action Plan Triggers

The Model is for a 10-year term. During that period, there are specified events that will lead to further review, corrective action, or potentially early termination of a model component or the model. In particular, Section 1115A(b)(3)(B) of the Social Security Act requires the Secretary to terminate or modify the design and implementation of a model unless the Secretary determines that the model is expected to:

- (1) Improve quality without increasing spending;
- (2) Reduce spending without reducing quality; or
- (3) Improve quality and reduce spending.

Warning Notice and Corrective Action Plan (CAP)

If CMS determines that a triggering event has occurred, they will provide written notice to Maryland and Maryland will submit a written response within 45 days of this notice. CMS will then review and determine if the response is appropriate or if Maryland will need to submit a Corrective Action Plan (CAP) within 30 days. Maryland will not be required to submit a CAP if the Triggering Event or Other Event was caused solely by reliance on federal Medicare per capita cost growth estimates and CMS determines that Maryland can make corrective action through the Hospital Payment Program for the following Model Year in accordance with the terms of the Agreement. Triggering events include:

- A material breach by Maryland of any provision of the Agreement.

- For each Model Year from MY1 until CMS and Maryland agree upon a Compounded Savings Target, if CMS determines that Maryland failed to meet the applicable Annual Savings Target by \$100 million or more. CMS and Maryland will agree to alternative Triggering Events, in conjunction with agreeing upon the Compounded Savings Target methodology.
- A determination by CMS that the quality of care provided to Medicare, Medicaid, or CHIP beneficiaries has deteriorated.
- A determination by CMS that Maryland has taken any action that threatens the health or safety of a Medicare beneficiary or other patient.
- A determination by CMS that Maryland has taken actions that compromise the integrity of the Model or the Medicare Trust Funds.
- If Maryland submits false data or makes false representations, warranties, or certifications in connection with any aspect of the Model.
- If Maryland makes any changes to Md. Code Ann. Health-Gen. §19-201 et seq., and CMS determines, in CMS's sole discretion, that such changes are not consistent with the requirements of this Agreement.
- If Maryland enacts legislation that inhibits the ability of Maryland Payers to participate in Maryland's health insurance market, and CMS determines, in CMS's sole discretion, that such changes are not consistent with the requirements of this Agreement.

Other Events will occur where CMS will take corrective action. However, by themselves, an Other Event will not lead to termination of the Agreement or performance period. Other Events include, but are not limited to:

- From MY1 until CMS and Maryland agree upon a Compounded Savings Target methodology, if CMS determines that Maryland did not meet the Annual Savings Target more than \$30 million and less than \$100 million.
- For any Model Year, if CMS determines that the annual growth rate in the Maryland Medicare TCOC per Beneficiary exceeds the TCOC Guardrail of 3.58 percent.
- CMS determines that a Model Program is not achieving savings or improving quality.
- A determination by CMS that Maryland has failed to demonstrate that Maryland's hospital quality and value-based payment program achieves or surpasses the measured results in patient outcomes and cost-savings obtained under the CMS VBP programs.
- A determination by CMS that Maryland has failed to meet the Revenue at Risk standard.
- A determination by CMS that Maryland has failed to comply with the conditions associated with one or more Medicare payment waivers granted.
- If Maryland enacts legislation that CMS determines, in CMS's sole discretion, will significantly increase Medicare TCOC in Maryland.
- A material breach of a CRP Participation Agreement.

CMS will immediately or with advance notice terminate a Model Program, a Model Program Participation Agreement, the Performance Period of the Model, or this Agreement if CMS, in its sole discretion, determines that:

- Maryland has not submitted or successfully implemented a required CAP
- Maryland has not timely complied with a corrective action required by CMS

Maryland will terminate a Model Program, a Model Program Participation Agreement to which Maryland is a Party, the Performance Period of the Model, or this Agreement at any time for any reason upon 180 days advance written notice to CMS.

Waiver Transition Plan

The TCOC Model will operate under Section 1814(b)(3) of the Social Security Act. In the event a triggering event leads to termination of the Model, Maryland will transition to national Medicare programs or another alternative model over a two-year period, to be negotiated by Maryland and CMS.

Evaluation of the Model

Maryland will provide annual reports addressing the following:

- Demonstrate Maryland’s efficacy in developing standardized value-based programs for hospitals
- A portfolio of evaluations measuring the ability of an all-payer system to transform the health delivery system from volume-based incentives to value-based incentives
- Impact on patient quality of care
- Assessment on the financial impact to commercial beneficiaries
- Impact on population health

Maryland will cooperate with CMS and its contractors by providing data needed to assess the impact of the Innovation Center Waiver. Where necessary, Maryland will require its providers, commercial payers and other individuals or entities performing functions under the Innovation Center waiver to provide such data. Data include but are not necessarily limited to claims data, administrative data, clinical/electronic health record data, site access to perform qualitative evaluation, information on the types of interventions models and care delivery programs.

Exogenous Factors, Prince George’s County, ACA impact

Maryland and CMS recognize the potential for exogenous factors to affect cost growth and other performance metrics, both for the all-payer and Medicare trends, in unpredictable ways. For example, Maryland could experience a localized disease outbreak that does not occur in other parts of the nation. Additionally, the Agreement will specifically identify four future events that could impact the projected trend:

- (1) Changes in health insurance coverage and funding, which are currently available under the Affordable Care Act,
- (2) Construction of a new hospital facility in Prince George’s County,
- (3) Rapid adoption speed of a new technology, and
- (4) Investments in care redesign at an accelerated pace.

Additional Information

Please visit the HSCRC website at <http://hscrc.maryland.gov/pages/default.aspx> for additional information or updates.