

Maryland All-Payer Model's Care Redesign Program
External FAQs
June 21th, 2018

GENERAL

Q: What is the Care Redesign Program?

A. The Care Redesign Program (“CRP”) is a voluntary program available within the Maryland All-Payer Model that focuses on care redesign and aligning financial incentives across hospitals and other providers and suppliers. The CRP provides Maryland hospitals the opportunity to partner with and provide incentives and resources to other providers and suppliers (“Care Partners”) in exchange for their performance of activities and processes that support statewide efforts to improve quality of care and reduce growth in total cost of care (“TCOC”) for Maryland Medicare beneficiaries.

Q: When does the CRP start and how long will it last?

A. The CRP is part of the Maryland All-Payer Model. It began on July 1, 2017 and will end on December 31, 2018 when the term of the All-Payer Model ends.

The CRP consists of three performance periods. The first performance period began on July 1, 2017 and ends on December 31, 2017. CMS and the State of Maryland agreed to an Amendment to the All-Payer Model in June of 2018. Due to the changes to the CRP, the second performance period begins on January 1, 2018 and ends on June 30th, 2018. A third performance period will begin on July 1st, 2018 and end on December 31st, 2018.

Q: What changes have been made to the CRP?

A. CMS and the State of Maryland agreed to an Amendment to the All-Payer Model in June of 2018. The Amendment requires the HSCRC to calculate a Medicare Performance Adjustment (“MPA”) for each hospital participating in the All-Payer Model that is also participating in the CRP. CMS and the State also agreed to make changes to the CRP to remove the TCOC guardrails in light of the MPA.

Q: What is the Medicare Performance Adjustment?

CMS has approved a proposal by the State of Maryland to create a TCOC benchmark for each Maryland hospital. The State will attribute Medicare FFS beneficiaries in Maryland to a hospital. If the costs for the attributed beneficiaries exceeds the benchmark, then CMS will reduce Medicare global budget payment to the hospital in the subsequent year. The MPA will hold hospital accountable for the full spectrum of care for their beneficiaries and will be subject to a quality adjustment score using measures comparable to those in the Merit-Based Incentive Payment System (MIPS). The MPA means that the All-Payer Model meets the criteria of an Advanced APM that payment for covered professional services be based on MIPS-comparable quality measures.

Q: What is the HSCRC's role in the CRP?

A. The CRP is designed to provide the State with flexibility to both design and assist with the implementation of the CRP. The HSCRC can propose changes to the CRP, including new or

updated CRP Tracks, CRP Interventions, payment methodologies, and Care Partner Qualifications. Any proposed changes to the CRP must be approved by CMS. In addition to assisting in the design of the CRP, the HSCRC will also review CRP Hospitals' reporting (as required in the CRP Participation Agreement), monitor and evaluate Participant Hospitals' performance under each CRP track, and report to CMS on the implementation of the CRP. CMS will also conduct its own monitoring and evaluation of the CRP.

Additional information about the HSCRC's role in the CRP can be found on the HSCRC's website: <http://www.hscrc.state.md.us/>.

Q: Does participation in the CRP qualify a participant as a Qualifying APM Participant (QP) in an Advanced Alternative Payment Model (APM) under the Quality Payment Program?

A. Yes. With the changes to include the MPA, the Maryland All-Payer Model is now an Advanced APM for the third performance period. A clinician who enters into a written financial arrangement ("Care Partner Arrangement") with a hospital participating in the CRP may be eligible to become a QP.

Q: Where can I find more information about the Quality Payment Program and Advanced APMs?

A. More information about the Quality Payment Program and Advanced APMs can be found CMS' at: <https://qpp.cms.gov>.

Q: Are there any waivers of fraud and abuse laws for the CRP?

A. Yes. With respect to certain fraud and abuse laws in sections 1128B and 1877 of the Social Security Act, the Secretary has issued waivers pursuant to §1115A(d)(1) for the CRP. The waivers protect only certain financial arrangements that are entered into pursuant to the CRP, if the arrangement complies with the terms of the applicable waiver. The waivers do not apply to other arrangements that may be entered into pursuant to the Maryland All-Payer Model. The waivers may be found here: <https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Fraud-and-Abuse-Waivers.html>.

CRP PARTICIPANTS

Q: Which hospitals are eligible to participate in the CRP?

A. Any acute care hospital located in Maryland that is participating in the Maryland All-Payer Model is eligible to participate in the CRP. A hospital that has executed a CRP Participation Agreement is referred to as a CRP Hospital.

Q: Are hospitals currently participating in the Maryland All-Payer Model required to participate in the CRP?

A. No. Participation in the CRP is voluntary. Hospitals participating in the CRP ("CRP Hospitals") may withdraw from the CRP at any time without penalty. CRP Hospitals are required to notify CMS and the State at least 90 days before any planned date of withdrawal.

Q: Can a hospital start participating in the CRP at any time?

A. A hospital may start participating in the CRP on the first date of either performance period after it has executed a CRP Participation Agreement with CMS and the State. To start participating in the CRP for the third performance period, a hospital must submit its executed CRP Participation Agreement to CMS on or before July 1st, 2018.

Q: How can a hospital start participating in the CRP?

A. To participate in the CRP, a hospital must execute a CRP Participation Agreement and upload it via a CMS online portal. The portal is located at the following website: <https://appl.innovation.cms.gov/allpayer>. For questions about the CRP, please email MarylandModel@cms.hhs.gov.

Q: Who can be a Care Partner?

A. A Care Partner is a provider or supplier who is enrolled in Medicare, furnishes items and services to Maryland Medicare beneficiaries, and has a Care Partner Arrangement. Each CRP Track includes additional criteria with which a Care Partner must comply in order to participate in that particular CRP Track (“Care Partner Qualifications”). A Care Partner may receive Incentive Payments, Intervention Resources, or both, from a CRP Hospital only if that Care Partner has been approved by CMS and is identified on the CRP Hospital’s Care Partner List.

Q: Can an individual or entity be a Care Partner with more than one CRP Hospital?

A: Yes. A Care Partner must enter into a Care Partner Arrangement with each CRP Hospital.

Q: How can a physician group practice (PGP) or its members participate in the CRP?

A: A PGP can participate in the CRP as a Care Partner if it enters into a written Care Partner Arrangement with a CRP Hospital. If a PGP is a Care Partner, its members can participate as Downstream Care Partners. A member of a PGP (“PGP Member”) may participate in the CRP as a Care Partner if he or she enters into a Care Partner Arrangement with a CRP Hospital, provided that his or her PGP does not already have a Care Partner Arrangement with that CRP Hospital. A CRP Hospital can distribute Intervention Resources to PGP Care Partners, but not to Care Partners that are PGP Members.

Q: What is a Care Partner Arrangement?

A. A Care Partner Arrangement is a financial arrangement between a 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 specific CRP Interventions selected by the CRP Hospital through its Track Implementation Protocol (“Allowable CRP Interventions”).

Q: What is a Downstream Care Partner Arrangement?

A. A Downstream Care Partner Arrangement is a financial arrangement between a PGP Care Partner and an individual who is a PGP Member of a PGP Care Partner, is enrolled in Medicare, provides items and services to Maryland Medicare beneficiaries, satisfies any applicable Care Partner Qualifications, and is identified on the Participant Hospital’s Care Partner List (“Downstream Care Partner”). Pursuant to such an arrangement and the CRP Track in which the Downstream Care Partner participates, the Downstream Care Partner may receive a monetary payment made by a PGP Care Partner to a Downstream Care Partner solely in exchange for

Allowable CRP Interventions actually performed on a Medicare FFS Beneficiary by the Downstream Care Partner (“Downstream Incentive Payment”).

Q: Can a PGP Care Partner adopt a written policy that requires its employed Downstream Care Partners to comply with the PGP Care Partners’ Care Partner Arrangement?

A: Yes. A written policy adopted by the PGP Care Partner that requires its employed downstream providers to comply with terms of the Care Partner Agreement would satisfy the requirements of Section 5.1(b) of the Participation Agreement.

Q: Can a Hospital require its Care Partners to adopt a written policy requiring employed providers or suppliers to abide by the requirements of Article II of the Participation Agreement?

A. Yes. Requiring a Care Partner to adopt a written policy requiring employed providers or suppliers participating in the Care Redesign Program abide by the requirements of Article II of the Participation Agreement would satisfy the requirements of Section 7.2(a) of the Participation Agreement.

Q: Can CRP Hospitals and Care Partners participate in both the CRP and other CMS programs or models?

A. Care Partners and Downstream Care Partners that participate in the CRP may also participate simultaneously in a Medicare Shared Savings Program (MSSP) ACO. Participation in other models will be reviewed on a case-by-case-basis to determine the extent of potential overlap and whether CRP Hospitals, Care Partners, and/or Downstream Care Partners should be excluded from the new model as potential participants, or whether the CRP Participation Agreement needs to be amended.

CRP TRACKS AND CARE INTERVENTIONS

Q: What is a CRP Track?

A CRP Track is a care redesign initiative developed by the Health Services Cost Review Commission (HSCRC), the Maryland Department of Health and Mental Hygiene (DHMH), and CMS, and implemented by a CRP Hospital with the assistance of its Care Partners. The CRP is designed to have one or more CRP Tracks available to CRP Hospitals for each performance period. Each CRP Track is designed to include specific providers and suppliers to participate as Care Partners, and to incentivize those Care Partners to perform specific activities or processes designed to improve or support the care that Maryland Medicare beneficiaries receive.

Q: What types of CRP Tracks will be available under the CRP?

A. The State proposed and CMS approved two CRP Tracks for the CRP’s first performance period:

- The **Hospital Care Improvement Program (HCIP)**, which allows CRP Hospitals to partner with hospital-based specialists to improve care coordination during and after a hospital admission.
- The **Chronic Care Improvement Program (CCIP)**, which allows CRP Hospitals to partner with primary care physicians and other community-based providers to improve care coordination and care management outside the hospital.

The State may propose additional CRP Tracks, subject to CMS approval, for the second performance period.

Q: What is a CRP Intervention?

A. A CRP Intervention is an activity or process 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. The CRP Interventions are unique to each CRP Track and are set forth in the relevant Track Implementation Protocol.

Q: What is a Track Implementation Protocol?

A. A Track Implementation Protocol is a form that has been approved by CMS that is designed to be completed by a CRP Hospital and to set forth the hospital's plan for implementing a CRP Track.

Q: What is an "IP Failure"?

A. An IP Failure occurs when a hospital implements the CRP in a manner that deviates from the its previously approved Track Implementation Protocol. The State may initiate a Performance Improvement Plan with the Hospital that requires the Hospital to change its implementation of the CRP in order to align with its approved Track Implementation Protocol or that requires the Hospital to amend its Track Implementation Protocol.

Q: What changes will Care Partners be expected to make in their care delivery?

A. A Care Partner will be required to perform one or more of the Allowable CRP Interventions specified in the CRP Hospital's Track Implementation Protocol. As part of the HCIP, Care Partners will improve delivery of inpatient medical and surgical services and support effective transitions of care and delivery of care during acute care events both in the hospital and beyond hospital walls. The CCIP will facilitate practice transformation towards patient-centered care that provides improved outcomes. Care Partners participating in the CCIP will focus on improving the care for beneficiaries with chronic and complex conditions by facilitating practice transformation towards patient-centered care.

Q: What learning and technical assistance support will the CRP offer to CRP Hospitals?

A. The HSCRC will provide interactive webinars and technical assistance support to CRP Hospitals.

Questions about the CRP, may be emailed to MarylandModel@cms.hhs.gov.

PAYMENT DESIGN

Q: What financial incentives are available under the CRP?

A. Under the CRP, CRP Hospitals will enter into Care Partner Arrangements with Care Partners pursuant to which the Care Partner may receive Incentive Payments, Intervention Resources, or both, in exchange for performing Allowable CRP Interventions. An Incentive Payment is a monetary payment made by the Hospital directly to a Care Partner solely for Allowable CRP Interventions actually performed on a Medicare FFS Beneficiary by the Care Partner during a specified period of time not to exceed a performance period. An Intervention Resource is nonmonetary remuneration furnished by the Hospital directly to a Care Partner for the purpose of assisting the Care Partner (or in the case of a Care Partner that is a PGP, its PGP Members) in performing care management and the CRP Interventions for Medicare FFS Beneficiaries.

Q: What safeguards are in place under the CRP?

A. For each performance period, a CRP Hospital may use no more than the Intervention Resource Allocation amount, as determined by the HSCRC, to fund Intervention Resources that it will provide to its Care Partners. The CRP Hospital must also attain Medicare cost savings for a CRP Track through the reduction of Potentially Avoidable Utilization (PAU) and other savings that the Hospital achieved as a result of the reduced PAU, as determined by the HSCRC (“PAU Savings”).

For each performance period and each CRP Track in which a CRP Hospital participates, the aggregate amount of Incentive Payments distributed by the CRP Hospital to any of its Care Partners must not exceed the CRP Hospital’s Incentive Payment Pool for that CRP Track. The HSCRC will determine the Incentive Payment Pool 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 track.

Q: Do the incentives and financial arrangements under the CRP impact a hospital’s Medicare payment under the All-Payer Model?

A. No. A CRP Hospital’s Medicare payment under its global budget will not be affected. The CRP allows CRP Hospitals to provide Incentive Payments to Care Partners from PAU Savings attained under its global budget. The CRP will not result in additional Medicare funding outside of the All-Payer Model.

OTHER FREQUENTLY ASKED QUESTIONS

Q: When does a hospital notify CMS of changes in its CRP Committee?

A. The hospital should report any changes in its CRP Committee with its next submission of a Track Implementation Protocol.

Q: Can a hospital system form a system-wide CRP Committee?

A. Yes. Each participating hospital should report the members of the shared CRP Committee in their Implementation Protocol.

Q: How can a beneficiary opt out of data sharing with participating hospitals?

A. Beneficiaries should call 1-800-MEDICARE to opt-out of data sharing.

Q: Are CRP Hospitals required to report whether the hospital or any of its Care Partners or Downstream Care Partners are subject to any sanctions or investigations?

A. Yes, the CRP Participation Agreement requires a CRP Hospital to notify CMS, the HSCRC and the DHMH if the hospital, one of its Care Partners, or one of its Downstream Care Partners is under investigation by, or has been sanctioned by, the federal government or any health licensing authority. We expect the CRP Hospital to notify CMS of any sanctions that it discovers, but we clarify that reportable investigations are limited to investigations related to participation in federal healthcare programs and federal and state licensing requirements. For example, the hospital would not need to notify CMS of labor disputes or routine claims reviews.

Additionally, we expect CRP Hospitals to notify CMS after a Care Partner or Downstream Care Partner has notified the CRP Hospital that it is under investigation by or has been sanctioned by the federal government or any health licensing authority. We rely on the CRP Hospital to impose reporting obligations on the Care Partner or Downstream Care Partner in the relevant Care Partner Arrangement regarding the reporting of sanctions and investigations. Finally, we note that although the failure to notify CMS of any investigation or sanction within 15 days would constitute noncompliance with the CRP Participation Agreement, it would not necessarily result in the imposition of remedial action. Whether CMS would take remedial action and the nature of that remedial action would depend on the facts and circumstances.