Regional Partnership Catalyst Grant Program

January 30, 2020

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Funding Announcement

The Health Services Cost Review Commission (HSCRC) is seeking proposals for the new Regional Partnership Catalyst Grant Program. This funding program is intended to support hospitals' continuing work with community resources on building the foundation needed to sustainably support the population health goals of the Total Cost of Care (TCOC) Model. Under the Regional Partnership Catalyst Grant Program, hospitals and their partners will collaborate to implement or expand investments in the two announced statewide population health priority areas – diabetes prevention & management and behavioral health crisis services. The Regional Partnership Catalyst Program is a temporary funding mechanism intended to encourage eligible hospitals to work together with community partners on building important foundations to improve population health. Funding will be issued for the following five year period:

- Year 1: CY2021 (January 1, 2021 – December 31, 2021)
- Year 2: CY2022 (January 1, 2022 – December 31, 2022)
- Year 3: CY2023 (January 1, 2023 – December 31, 2023)
- Year 4: CY2024 (January 1, 2024 – December 31, 2024)
- Year 5: CY2025 (January 1, 2025 – December 31, 2025)
- Grant funding will end on December 31, 2025.

Proposal Requirements and Timeline

Proposals must be single-spaced, single sided, Calibri style and 11 point font size and submitted using the requirements described herein by the date below to hscrc.rfp-implement@maryland.gov in order to be considered. **Separate proposals must be submitted for each funding stream.** A review committee appointed by the HSCRC will review the applications and make decisions about awards.

- Funding Announcement: January 31, 2020
- Proposal Deadline: June 19, 2020, 11:59 pm EST
- Proposal Disposition Notifications – September 2020
- Commission Draft Award Recommendations – October 2020
- Commission Final Award Recommendations – November 2020
- Rate Orders Issued – January 2021

Background

The Maryland All-Payer Model, which launched in 2014, established global budgets for Maryland hospitals to reduce Medicare hospital expenditures and improve quality of care. Global budgets provide hospitals with a fixed amount of revenue for the upcoming year. A global budget encourages hospitals to eliminate unnecessary hospitalizations, among other benefits. Under the All-Payer Model, Maryland achieved significant savings for Medicare and improved quality. However, the Maryland All-Payer Model historically focused primarily on the hospital setting, constraining the State's ability to sustain its rate of Medicare savings and quality improvements.

In 2019, the Centers for Medicare & Medicaid Services (CMS) and the State of Maryland initiated the Maryland Total Cost of Care (TCOC) Model, which seeks to broaden transformation of Maryland's healthcare system by setting a per capita savings target on Medicare total cost of care in the State. The TCOC Model builds on the success of Maryland's All-Payer Model by creating greater incentives for health care providers to coordinate with each other and provide patient-centered care, and by committing the State to a sustainable growth rate in per capita total cost of care spending for Medicare beneficiaries.

The TCOC Model holds Maryland fully at risk for the total cost of care for Medicare beneficiaries and sets Maryland on course to save Medicare over $1 billion by the end of 2023 by adopting new and innovative policies aimed at improving care, improving population health, and moderating the growth in hospital costs. The goal of the TCOC Model is to transform Maryland's health care system to be highly reliable, highly efficient, and a point of pride in our communities by increasing collaboration among health systems, payers, community hospitals, ambulatory physician practices, long-term care, and other providers, as well as patients and families, public health, and community-based organizations.

While changes to hospital payment mechanisms consistent with the All-Payer Model are well under way, the new TCOC model requires continued work and investments to integrate and support the efforts of additional parts of the healthcare systems including independent ambulatory physicians, community providers, public health, and others to improve care delivery for patients. In its November 2019 public meeting, the Commission approved the creation of temporary Regional Partnership Catalyst Grants to support hospitals' engagement with community resources to build the foundation needed to sustainably support the population health goals of the TCOC Model.

Maryland hospitals that have global budgets established under the rate-setting authority of the HSCRC and meet the additional requirements identified in this announcement are eligible to apply for the Regional Partnership Catalyst Grants. *Awards will only be available to the most promising and competitive hospital applicants.* The aggregate amount available for Regional Partnership Catalyst Grant Program is up to 0.25 percent of statewide hospital revenue. The maximum amount a hospital may receive from multiple successful proposals may not exceed 0.75 percent of the hospital's FY 2020 approved net patient revenue plus markup.

Regional Partnership Catalyst Grants

The Regional Partnership Catalyst Grants will be narrowly focused to support activities that align with goals of the TCOC Model and the Memorandum of Understanding that Maryland established with CMS for a Statewide Integrated Health Improvement Strategy (SIHIS). The Regional Partnership Catalyst Grant Program will include allocations of funds called "funding streams" that are designed to encourage focus on the key state priorities. This funding announcement is for the following two funding streams that will have funds issued in January 2021 through hospital rate orders:

- **Funding Stream I: "Diabetes Prevention & Management Programs**" – This funding stream awards grants to Regional Partnerships in order to support the implementation of the Centers for Disease Control (CDC) approved diabetes prevention and American Diabetes Association (ADA) recommended diabetes management programs and related interventions that will strengthen the diabetes prevention and management programs.

- **Funding Stream II: "Behavioral Health Crisis Programs"** – This funding stream would award grants to Regional Partnerships to support the implementation and expansion of behavioral health crisis management models that improve access to crisis intervention, stabilization, and treatment referral programs.

The Regional Partnership Catalyst Grant Program may also include a third funding stream that will award grants to Regional Partnerships to support one additional population health priority area that Maryland may define. A separate funding announcement would be issued for the third priority area.

The intent of the Regional Partnership Catalyst Grant Program is to achieve the following:

- Partnerships and strategies that result in long term improvement in the population health metrics that are part of the new TCOC Model
- Increased number of prevention and management services for persons with potential for or living with diabetes
- Reduced use of hospital emergency departments and improved approaches for managing acute behavioral health issues
- Integration and coordination of physical and behavioral health services for improved quality of care
- Engagement and integration of community resources into the transforming healthcare system

Hospitals interested in applying will be required to submit proposals describing how they will use the Regional Partnership Catalyst Grant Program funds to work in collaboration with Local Health Improvement Coalitions, Local Health Departments, community-based organizations,

local behavioral health authorities, social service organizations, physician groups, etc. to build the foundation that will support improvement in population health in the long run. Successful hospital proposals will articulate detailed plans for implementing or expanding support systems in the aforementioned population health priority areas.

Funding Stream I: Diabetes Prevention & Management

The diabetes funding stream will competitively award grants to Regional Partnerships that choose to implement and support the Centers for Disease Control and Prevention (CDC) recommended National Diabetes Prevention Program (National DPP). Maryland needs significantly more diabetes prevention and management resources in order to provide the service to all Marylanders in need. Given the State's shortage of resources, Regional Partnership Catalyst awards are intended to help hospitals work with community resources to build a more adequate National DPP provider capacity within Maryland that becomes available for the entire health system to utilize.

As an additional component of the diabetes funding stream, funds will also be competitively awarded to develop, promote, and track development of Diabetes Self-Management Training (DSMT). Regional Partnerships may submit plans to implement National DPP, DSMT, or both programs in the same proposal. Proposals should specify how hospitals in collaboration with community partners intend to increase the number of diabetes prevention and management resources and should include planning, startup, implementation, and operational costs.

Proposals may also include funding requests for additional diabetes related "wrap around services" -- programs that supplement National DPP and/or DSMT services and bolster the likelihood of a positive impact on diabetes burden in the Regional Partnership's geographic service area. Regional Partnerships can opt to implement Medical Nutritional Therapy (MNT) as an optional wrap around service to supplement National DPP and/or DSMT. Regional Partnerships may also propose other additional wrap around services. Proposals must detail how the wrap around services will align with and/or enhance National DPP and/or DSMT.

Funding Stream II: Behavioral Health Crisis

The behavioral health crisis services funding stream will competitively award grants to Regional Partnerships that choose to develop and expand comprehensive crisis management services that enable Marylanders to receive care in settings other than traditional hospital emergency departments. Proposals should include one or more of the following elements from the "Crisis Now: Transforming Services is Within Our Reach" action plan developed by the National Action Alliance for Suicide Prevention:

- Crisis Call Center & "Air Traffic Control" Services
- Community-Based Mobile Crisis Teams
- Short-term, "sub-acute" residential crisis stabilization programs

Proposals may also include funding requests for additional behavioral health crisis wrap around services that are intended to bolster the likelihood of a positive impact in the Regional Partnership's geographic service area. Proposals must detail how the wrap around services will align with and/or enhance the Crisis Now action plan elements.

Measuring Impact

Regional Partnerships that are awarded funds will be responsible for achieving HSCRC defined scale targets as a condition of grant continued funding. If scale targets are not achieved, the HSCRC may discontinue funding for the Regional Partnership. Appendices A-C represent *a preliminary list* of the scale targets and metrics that will be required for reporting. The final scale targets, metrics, and reporting requirements will be issued following the award process for each Regional Partnership. At that point, Regional Partnerships may opt to decline funding if they do not agree with newly added scale targets. Scale targets are pre-determined targets that Regional Partnerships will need to achieve during the grant period in order to receive continued funding. The targets will be set from data, such as claims, so that progress can be independently verifiable and objectively measured between Regional Partnerships. Regional Partnerships will *not* be accountable for a specific total cost of care savings goal during the grant period, but will instead be held accountable to achieve scale targets. For Regional Partnerships that opt to include wrap around services in their proposals, the Regional Partnership will still be accountable to achieve all established funding stream scale targets for core grant services (National DPP, DSMT, and Crisis Now behavioral health crisis services). Additionally, Regional Partnerships will also need to achieve the HSCRC defined scale targets set for wrap around services.

Eligibility Criteria

Maryland hospitals that have global budgets established under the rate-setting authority of the HSCRC are eligible to apply for the Regional Partnership Catalyst Grants. Proposals for a competitive Regional Partnership Catalyst grants may be submitted by:

- Multiple hospitals as lead applicants
- An individual hospital participant from a Regional Partnership as a lead applicant applying on behalf of a Regional Partnership

A hospital may participate in multiple Regional Partnership Catalyst Program proposals. There is no limit to the number of Regional Partnership Catalyst Grant Program proposals that any one hospital may join. Where a hospital is participating in multiple Regional Partnerships however, each proposal will need to demonstrate how the hospital plans and resources are distinct from one another. The maximum total dollars that may be awarded to an individual hospital is 0.75 percent of its FY 2020 approved net patient revenue plus markup whether the hospital participates in one or multiple Regional Partnership Catalyst Program proposals.

To be eligible for consideration, all proposals must include details about collaborating organizations that will be part of the Regional Partnership Catalyst Program. Details about arrangements for resource sharing, financial payments, and/or in-kind support must be disclosed in the proposals. Specifically, the proposal should clearly detail how resources, funds, or in kind support will flow to all partners. Proposals that include broad and meaningful partnerships and diverse approaches to engaging communities in implementing National DPP, DSMT, Crisis Now, and/or wrap around activities will receive higher points when scored than proposals that do not have strong collaboration models.

Competitive Regional Partnership Catalyst Grant Program awards are intended as an add-on to approved hospital rates. If awarded, enhanced reporting will be expected. Activities will be monitored and measured to demonstrate how funds have been used and to show the impact that the related programs and interventions have on diabetes and behavioral health metrics as well.

Proposal Requirements

Proposals must be submitted before the deadline. Proposals that are late, incomplete, or in a format that does not adhere to requirements specified will not be considered. Proposals must be formatted as follows:

- Section I: "Scope of Work" – this section of the proposal should describe in detail the proposed activities for the Regional Partnership.
- Section II: "Financial Projections" – the section of the proposal should describe in detail the proposed budget

Section I: Scope of Work

The scope of work section must include the seven sections listed below.

- Sections 1-7 of the proposal must be submitted as a PDF of Microsoft Word or similar formats and may not exceed 25 pages.
- Section 8 (Implementation Work Plan) must be submitted as a PDF of Microsoft Excel or a common project management software, such as Microsoft Project.

1. Summary of Proposal (3 Pages)

Regional Partnerships are required to summarize their proposal using the standard template in Appendix D for the required summary format table. Complete one summary table for each proposal submitted (e.g., one table for diabetes and one table for behavioral health crisis services).

2. Target Population

This section must define the geographic scope of the model via a comprehensive list of the ZIP codes and hospitals included, as well as counties and incorporated cities. Additionally, data and a corresponding narrative should be used to describe the health needs that the proposed activities will address within the proposed geographic area.

3. Proposed Activities

This section must include a description of the proposed model(s) to be implemented or expanded. The description should include information on the target patient population(s), the services and/or interventions the patients will receive, and the role of each participating partner in the program or intervention. This section should also describe the planning, foundation building (e.g., technology, workforce, delivery model, etc.), and outreach strategies that will be included in the proposed activities. The discussion of the proposed model should be very specific and describe the planning, implementation, and monitoring of all elements of the proposed model.

4. Measurement and Outcomes

HSCRC will work with CRISP to develop reporting tools that measure Regional Partnership progress towards scale targets. These tools will be made available to Regional Partnerships as they are developed. This section of proposals should describe additional tools the Regional Partnership will use to coordinate and measure its progress towards scale targets. This section also should describe the expected results and include baseline data and measures. Appendices A-C are a guide for types of measures that the HSCRC will use to gauge the success of the investment. In addition to high level goals that the applicants are pursuing, program-specific measures should be proposed by applicants. Applicants should provide the evidence basis for their approach.

5. Scalability and Sustainability

This section should detail how the intervention/program is sustainable after the grant period expires and funding is discontinued. Plans for funding an expansion of the program/intervention if it proves successful should also be described. The partners should demonstrate a commitment to sharing resources and addressing alignment of payment models on an ongoing basis.

6. Participating Partners and Decision-Making Process

This section should include a list of the participating entities and the roles they will play in the Regional Partnership's plan using the template in Appendix E. Additionally, this section should also include a description of a shared decision making process that incorporates the perspectives of all partners. If a formalized governance structure will be used, it should be described in this section. This section should describe the roles and responsibilities for

partnering organizations and the proposed funding for each.

7. Implementation Work Plan (no page limit to this non-narrative section, must be submitted as a PDF of Microsoft Excel or a common project management software, such as Microsoft Project)

This section should clearly describe how different initiatives will move from a planning to implementation phase, including when the intervention(s) will begin.

Section II: Financial Projections

1. Budget

Proposals must include a complete and comprehensive line item projected budget using the format in Appendix F to specify expected expenses and how funds, resources, and/or in-kind support will be distributed and flow to collaborating hospitals, providers, community-based organizations (CBOs) or other collaborating organizations. If more than one hospital applies as a lead applicant, the proposal and budget must clarify if:

- Each of the lead hospitals will receive an increase in rates to generate the funds to be shared in accordance with a proposal; or
- One of the collaborating hospitals will receive an increase in rates to be shared with the other collaborating hospitals.

Awarded funds will be issued to hospitals through rate orders, beginning in January 2021, with all funding expiring December 31, 2025. The proposed budget is expected to demonstrate the applicant's ability to execute the described scope of work to the extent practicable, within the grant period. For each year awards are made, it is expected that funds will be expended within twelve months of fund issuance. Budget projections should be based on no rollover of funds. Rollover of funds from one grant year to another grant year will not be allowed and unused funds, as determined through HSCRC staff audits, will be retracted through rates by HSCRC. Funds can only be used for planning, capital expenditures, implementation, service delivery and operating expenses related to the population health priority areas. The HSCRC reserves the right to terminate an award at any time for what it considers to be material lack of performance, (i.e. failure to achieve scale targets), or for its determination that a participating hospital is not meeting the letter or intent of an application as approved. If the HSCRC determines that a hospital has used award funds in a manner inconsistent with the approved proposal, the Commission may require repayment of those funds inappropriately used.

Examples of ineligible expenses are described in Appendix G.

2. Budget and Expenditures Narrative (no more than 3 pages)

Proposals must include a brief narrative justifying the expenses included in the line item budget. This section of the proposal should also include the percentage of the total investment of the program covered by the award and the source of any other funding that may apply to

support the proposed activities. Investments included in the budget should have the potential to impact the population health priority areas within the communities that each regional partnership serves. Additionally, investments included in the budget are expected to be data driven and able to be evaluated using measurable outcomes.

Evaluation Process

An evaluation committee formed by the HSCRC will review and score the grant proposals for both core and wrap around services. Additionally, the HSCRC will engage key subject matter experts with diabetes prevention/management and behavioral health crisis management expertise to assist in the review and evaluation of grant applications. The HSCRC will make awards based on applications received and will determine how funds are dispersed. This means that:

- Determinations by the evaluation committee are not subject to appeal;
- The evaluation committee may suggest alterations to the scope or amount of a proposal during the process; and
- The evaluation committee may require an applicant to alter a proposal or proposals to come into compliance with the award limitation described above.

After the evaluation committee process is complete, HSCRC staff will present a recommendation on award funding to HSCRC Commissioners who will approve final funding determinations. Commissioners may adjust the funding recommendations, at their discretion.

Evaluation Criteria

Applications will be reviewed and funding awarded based on the following criteria:

1. **Alignment with TCOC Model goals and population health priorities –** The potential for the proposed activities to achieve the scale targets in Appendices A-C.

2. **Widespread Engagement & Collaboration** – The extent to which community organizations with the ability to influence health in the priority areas have been engaged meaningfully through financial arrangements, resource sharing, and/or in-kind support.

3. **Evidence-Based Approaches** - Whether the proposed activities are well-conceived, evidence-based, and appropriately propose how to implement the investments in an efficient and effective manner to address the population health priority areas.

4. **Outreach and Engagement Approaches –** The degree to which effective healthcare consumer engagement strategies have been incorporated into the proposal with targets and measures. Approaches that will integrate input and feedback from diverse consumers, patients, clients, families, and caregivers into the outreach and education approach.

Outreach and engagement activities that directly engage consumers, patients, clients, families, and caregivers and lead to their improved understanding of disease prevention/health promotion, health conditions, access to resources and services, treatment options, medicines, devices, and other treatments , self-care, disease management, and personal responsibility for healthcare costs.

5. **Innovation** - The extent to which the proposed activities innovatively use health information technology (telehealth, electronic health records, health information exchange, etc.), community resources (community health workers, promotoras, peer recovery specialists, and other "helpers" and facilitators) to improve care and engage patients. The extent to which the proposed activities supports alignment and the use of information across partners in the regional partnership with the goal of improving the delivery of care in a manner that achieves the scale targets outlined in Appendix A-C.

6. **Sustainability Plan** - The extent to which the Regional Partnership has identified criteria to determine the effectiveness of proposed activities, long term costs, and alternative funding strategies in order to be successful beyond the five-year grant period.

7. **Implementation Plan** - Level of detail and feasibility of implementation plans including governance model to enable partners to work together effectively.

8. **Budget** - The reasonableness and adequacy of the proposed budget. A clear description of how awarded funds will be disbursed to organizations included in the proposal consistent with existing law.

Resources Available to All Hospitals

In an effort to support hospitals during the process of establishing their plans for Regional Partnerships, HSCRC will assemble resources and provide answers to frequently asked questions on the HSCRC website at: https://hscrc.maryland.gov/Pages/regional-partnerships.aspx. Additionally, during the RFP planning period, Regional Partnerships may opt to receive one-on-one technical assistance from HSCRC staff on RFP questions and proposal planning (on a limited basis for each proposal). To arrange technical assistance calls, contact:

Erin Schurmann
Center for Payment Reform & Provider Alignment
Maryland Health Services Cost Review Commission
Phone: 410.764.2577
Email: erin.schurmann@maryland.gov

Additional questions about the Regional Partnership Catalyst Grant Program may be submitted via email to hscrc.rfp-implement@maryland.gov.

Appendix A – Scale Targets Diabetes Prevention Program

General Philosophy: Developing access to the National Diabetes Prevention Program Lifestyle Change Program (National DPP) is an evidence-based intervention that will help the State achieve savings under its outcomes-based credit and by improving population health. The scale targets to support this program's development will focus on ensuring that new National DPP programs are being established and scaled to meet the needs of Maryland's population living with prediabetes. Therefore, the scale targets are not only focused on development of new services, but also recruitment of patients, retention and success of program participants. This multi-faceted approach will ensure that successful and sustainable programs are established through Regional Partnerships (RPs). The targets are intended to incentivize an all-payer approach, though will only be measured Medicare and Medicaid claims due to data limitations. Some targets repeat in two years to incent improvement and gradation of different focuses as RPs develop; for example, there is an enrollment target in both years three and four to continue focus and incent improvement in key metrics. Of note, targets are dependent upon one another and to meet future targets RPs should consult the estimated progression of referral, enrollment and completion outlined in Table 1 below. To facilitate reporting, HSCRC will work with CRISP over CY2020 to develop a reliable referral system and tracking mechanism for Regional Partnerships. The scale targets have been developed in consultation with National DPP experts, the State Medicaid program and existing National DPP programs within Maryland.

Regional Partnership funding intended to support wrap-around National DPP services will also be held to these scale targets since they are intended to optimize and support National DPP development. The scale targets are based on a relatively small prevalence rate of adults living with prediabetes (10.5 percent of adults) and therefore money accepted for direct National DPP services and wrap around services for optimizing National DPP should still have a measurable impact on National DPP claims.

Table 1. Expected Statewide National DPP Progression[1]

Regional Partnership Funding Year	Year 1	Year 2	Year 3	Year 4	Year 5
% of Population with Prediabetes in RP Service Area Referred to a National DPP	0%	10%	20%	30%	40%
Enrollment Rate of Referred Population	0%	5%	10%	20%	30%
% of Population with Prediabetes in RP Service Area Enrolled in National DPP	0%	0.5%	2%	6%	12%
Completion Rate (per Scale Target) of Referred Population	0%	10%	20%	35%	55%
% of Population with Prediabetes in RP Service Area Completing a National DPP	0%	0.1%	0.4%	2.1%	6.6%

Overall Methodology:

1. RP Submits Participating Hospitals for Funding Stream Interventions
2. HSCRC Establishes Baseline Population in the RP Zip codes
   a. National DPP Services – The prediabetes population as established by multiplying the statewide prediabetes prevalence average from the BRFSS adult estimate by the cumulative adult (ages 18+) population across an RP's selected zip codes. [2]
3. HSCRC Applies Evidence-based target to Baseline population (See Table Below)
4. HSCRC Establishes a target percentage for each Year of funding
5. HSCRC will report ongoing performance on all measures for RP tracking, targets will not change year over year

[1] https://ama-roi-calculator.appspot.com/
[2] https://phpa.health.maryland.gov/ccdpc/Reports/Documents/MD-BRFSS/BRFSS_BRIEF_2016-10_Prediabetes.pdf

RP Year	*Target*[3]	*Logic*	*Numerator*	*Num. Data Source*	*Denominator*	*Den. Data Source*	*Evidence-Based Target*
National DPP and Wrap Around National DPP Services Scale Targets Years 1-5							
1	At least 1 Preliminary, Pending or Full CDC-Recognized Program in service area with a LOS indicating Qualification in a Payment Program (MDPP or Medicaid)	In order to meet the following targets, RPs will need to ensure their National DPP partners are established or programs are in the CDC recognition process in year one.	N/A	N/A	N/A	N/A	Evidence-base indicates that establishment of services is possible within one year of operation.[4]
2	REFERRALS through CRISP	Determine if patients are being offered program and ensure outreach is growing and there is a strategic efficiency to moving beneficiaries into the program	Total participants referred through CRISP to a participating National DPP provider across all payers within the RP jurisdiction	CRISP	Adult population with prediabetes in RP service zip codes	BRFSS Prevalence[5] **AND** U.S. Census Bureau Adult population by zip[6]	10%[7]
3							20%[8]

[3] CPT codes for measurement are indicated in parenthesis, when applicable.
[4] Rehm CD, Marquez ME, Spurrell-Huss E, Hollingsworth N, Parsons AS. Lessons from Launching the Diabetes Prevention Program in a Large Integrated Health Care Delivery System: A Case Study. *Popul Health Manag*. 2017;20(4):262–270. doi:10.1089/pop.2016.0109. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5564042/
[5] 10.5 percent as of 2014 Survey. https://phpa.health.maryland.gov/ccdpc/Reports/Documents/MD-BRFSS/BRFSS_BRIEF_2016-10_Prediabetes.pdf
[6] https://data.imap.maryland.gov/datasets/eb706b48117b43d482c63d02017fc3ff_1
[7] https://ama-roi-calculator.appspot.com/
[8] Nhim K, Khan T, Gruss SM, et al. Primary Care Providers' Prediabetes Screening, Testing, and Referral Behaviors. *Am J Prev Med*. 2018;55(2):e39–e47. doi:10.1016/j.amepre.2018.04.017 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6241213/

3	ENROLLMENT *Medicare*: Submit claim for first session (G9873), OR Submit claim for Bridge Payment (G9890) *Medicaid*: G9873, E1639, or 0488T	To measure if enrollment is increasing in both Medicare and Medicaid programs, at least one claim for a National DPP service should be viewable in State data.	Medicare claims for a first session or bridge payment **AND** Medicaid claims for a first session (in-person or virtual) or milestone 1 (virtual)[9]	Medicare CCLF Medicaid Claims	Adult population with prediabetes in RP service zip codes	BRFSS Prevalence[4] **AND** U.S. Census Bureau Adult population by zip[5]	2%[6]
4							6%[6]
4	RETENTION *Medicare:* Submit claims indicating 9 core sessions attended (G9875) *Medicaid:* Sessions 5-9 retention (G9875) and Milestone 3 (G9875)	A successful National DPP program will keep beneficiaries as long as possible within a year of enrollment to ensure they have the best outcomes and benefit of the program.	Medicare and Medicaid claims indicating 9 core sessions or milestone 3	Medicare CCLF Medicaid Claims	Adult population with prediabetes in RP service zip codes	BRFSS Prevalence[4] **AND** U.S. Census Bureau Adult population by zip[5]	2.1%[6]
5							12.4%[6]

[9] Note: The Medicaid reimbursement structure contains two payment tracks for DPP services. The 'Session and Performance-Based Payments' track accommodates both in-person and virtual DPP providers and closely mirrors the MDPP (Medicare) payment schedule. The 'Milestone-Based Payments' track was built to accommodate virtual providers and aggregates payments into lump sums for certain timepoints/length of participation in the program. For more information, please contact Maryland's Medicaid administrators.

5	OUTCOMES *Medicare:* Submit codes indicating 5% or 9% bodyweight loss achieved or maintained (G9878, G9879, G9880, G9881) *Medicaid:* Bill any form of 5% or 9% bodyweight loss Reimbursement (G9878, G9879, G9880, G9881)	National DPP is an outcomes-based payment and sustainable RP programs will need to ensure they can show beneficiaries lose weight in their program for maximal reimbursement and return.	Medicare and Medicaid claims indicating 5% or 9% bodyweight loss.	Medicare CCLF Medicaid Claims	Adult population with prediabetes in RP service zip codes	BRFSS Prevalence[4] **AND** U.S. Census Bureau Adult population by zip[5]	1.8%[10]

[10] Diabetes Prevention Program Research Group, Knowler WC, Fowler SE, et al. 10-year follow-up of diabetes incidence and weight loss in the Diabetes Prevention Program Outcomes Study [published correction appears in Lancet. 2009 Dec 19;374(9707):2054]. *Lancet*. 2009;374(9702):1677–1686. doi:10.1016/S0140-6736(09)61457-4. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3135022/

Appendix B – Scale Targets Diabetes Management

General Philosophy: Impacting diabetes management care across the state will help improve population health, care outcomes and total costs of care. Diabetes education services or Diabetes Self-Management Training (DSMT) is a Medicare reimbursed intervention that can be offered in both the community and health care settings, making it ideal for the Regional Partnership structure. The scale targets for DSMT funding will initially focus on showing development and growth of DSMT to increase Marylanders' access to the services. Next, the targets will focus the RPs on retaining beneficiaries and bringing participants to benefit completion to maximize the behavior effect on those who access the program. The targets are intended to incentivize an all-payer approach, though will only be measured Medicare claims due to data limitations. Some targets repeat in two years to incent improvement and gradation of different focuses as RPs develop. Finally, diabetes outcomes will be measured from the aggregate Prevention Quality Indicator 93 (PQI93) measure for diabetic admissions developed by AHRQ.[11] While the effect of DSMT alone may be minimal on each RP's participating hospital's rate of PQI93, HSCRC staff believe that duplication with the Potentially Avoidable Utilization (PAU) reimbursement incentive policy and the all-payer application facilitates amplified hospital focus. Staff have aligned the expected reduction with the State's Diabetes Action Plan's targeted hospitalization reductions.

For wrap around DSMT services requesting RP funding, the creation of scale targets based on a common outcome presents operational and equity issues. To effectively evaluate the impact equally across RPs, HSCRC staff will again utilize the common PQI93 measure. The measure will also benefit from added hospital focus in the PAU program and will mirror that of DSMT services mentioned above.

Overall Methodology:

1. RP Submits Participating Hospitals for Funding Stream Interventions
2. HSCRC Establishes Baseline Population in the participating RP Hospitals,
    a. DSMT Services – Medicare diabetic population as determined by an ICD-10 diagnosis code for diabetes within baseline year.
    b. Non-DSMT Services -- The Medicare diabetic population as determined by an ICD-10 diagnosis code for diabetes within baseline year.
3. HSCRC Applies Evidence-based target to Baseline population (See Table Below)
4. HSCRC Establishes a target percentage for each Year of funding
5. HSCRC will report ongoing performance on all measures for RP tracking, targets will not change year over year

[11] https://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V60-ICD10/TechSpecs/PQI_93_Prevention_Quality_Diabetes_Composite.pdf

RP Year	*Target*[12]	*Logic*	*Numerator*	*Num. Data Source*	*Denominator*	*Den. Data Source*	*Evidence-Based Target*
DSMT Services Funding Scale Targets Year 1-5							
1	American Diabetes Association (ADA) Accreditation	The ADA provides resources and accreditation for DSMT programs so that they may receive Medicare reimbursement, without demonstrating this progress RPs will not be successful in meeting the following claims-based metrics.	Either ADA DSMT Accreditation or a Letter of Support from an existing community partner with an accreditation.	RP Self-Report, HSCRC Audit	N/A	N/A	N/A
2	Initiation of DSMT Services *Medicare*: At least one claim for DSMT (G0108 or G0109)	Initiation of DSMT must reach a critical mass so that providers reach critical efficiency	Continuously enrolled Part A and B Medicare beneficiaries **WITH** at least one claim for DSMT services (G0108 or G0109)	Medicare CCLF	Continuously enrolled Part A and B Medicare beneficiaries **WITH** At least one ICD-10 code for indicating diabetes **WITHIN** RP Hospitals' Service Area[13]	Medicare CCLF	15%[14,15,16]
3							25%[3,4,5]

[12] Parentheses indicate CPT code for measurement in Medicare claims, when applicable.

[13] "Within RP Hospitals' Service Area" refers to inpatient and outpatient claims associated with a hospital and Regional Partnership's member hospitals.

[14] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/DSMT-Accreditation-Program

[15] Li R, Shrestha SS, Lipman R, et al. Diabetes self-management education and training among privately insured persons with newly diagnosed diabetes--United States, 2011-2012. *MMWR Morb Mortal Wkly Rep*. 2014;63(46):1045–1049. https://pubmed.ncbi.nlm.nih.gov/25412060-diabetes-self-management-education-and-training-among-privately-insured-persons-with-newly-diagnosed-diabetes-united-states-2011-2012/

[16] Strawbridge, L. M., Lloyd, J. T., Meadow, A., Riley, G. F., & Howell, B. L. (2015). Use of Medicare's Diabetes Self-Management Training Benefit. Health education & behavior : the official publication of the Society for Public Health Education, 42(4), 530–538. doi:10.1177/1090198114566271 https://pubmed.ncbi.nlm.nih.gov/25616412-use-of-medicares-diabetes-self-management-training-benefit/

3	Retention of Participants *Medicare:* Beneficiaries who have five or more claims for DSMT (G0108 or G0109)	For DSMT programs to have maximal impact participants must stay in the program and RPs must optimize their services to do so.	Continuously enrolled Part A and B Medicare beneficiaries **WITH** at least five claims for DSMT services (G0108 or G0109)	Medicare CCLF	Continuously enrolled Part A and B Medicare beneficiaries **WITH** At least one ICD-10 code for indicating diabetes **WITHIN** RP Hospitals' Service Area[13]	Medicare CCLF	15%[3,4,5]
4							20%[3,4,5]
5	Completion Rate *Medicare:* Beneficiaries who have ten or more claims for DSMT (G0108 or G0109)	For DSMT programs are designed to produce an outcome by the end of the benefit, which is ten sessions per beneficiary per lifetime.	Continuously enrolled Part A and B Medicare beneficiaries **WITH** at least ten claims for DSMT services (G0108 or G0109)	Medicare CCLF	Continuously enrolled Part A and B Medicare beneficiaries **WITH** At least one ICD-10 code for indicating diabetes **WITHIN** RP Hospitals' Service Area[13]	Medicare CCLF	5%[3,4,5]
5	Diabetes Outcomes PQI93 Rate by hospital participating in each RP	Impacting management of diabetes should show an impact on the outcomes for diabetes patients, especially with regards to prevention quality and admissions measured by PQI93.	Inpatient or Observation visits >= 24 hrs flagged with PQI93 **WITHIN** RP Hospitals' Service Area	HSCRC Casemix Data	Maryland adults **WITHIN** RP Hospitals' Service Area[12]	5-year American Community Survey	5% reduction[8]

Wrap Around DSMT Services Scale Targets for Year 3 and 5							
3	OUTCOMES PQI93 Rate by hospital participating in each RP	Impacting management of diabetes should show an impact on the outcomes for diabetes patients, especially with regards to prevention quality and admissions measured by PQI93.	Inpatient or Observation visits >= 24 hrs flagged with PQI93 **WITHIN** RP Hospitals' Service Area	HSCRC Casemix Data	Maryland adults **WITHIN** RP Hospitals' Service Area[12]	5-year American Community Survey	2.5% reduction[17]
5	OUTCOMES PQI93 Rate by hospital participating in each RP	Impacting management of diabetes should show an impact on the outcomes for diabetes patients, especially with regards to prevention quality and admissions measured by PQI93.	Inpatient or Observation visits >= 24 hrs flagged with PQI93 **WITHIN** RP Hospitals' Service Area	HSCRC Casemix Data	Maryland adults **WITHIN** RP Hospitals' Service Area[12]	5-year American Community Survey	5% reduction[8]

[17] Maryland Diabetes Action Plan https://phpa.health.maryland.gov/CCDPC/Pages/diabetes-action-plan.aspx

Appendix C – Scale Targets Behavioral Health Crisis Services

General Philosophy: Crisis Services will take time to build and scale to a measurable impact within each hospital. The HSCRC has consulted experts and literature to develop reasonable targets to ensure the impact and sustainability of funding.[18,19,20] The first three years of Regional Partnership funding will be dedicated to building crisis services and establishing efficient interventions. By the fourth year of implementing crisis services, hospitals should experience a reduction in Emergency Department (ED) boarding times as hospitals more efficiently begin diverting and referring patients to newly created crisis centers. Finally, as crisis centers become more established in the community and connect to other emergency systems like police and EMS, hospitals should experience an overall reduction in the number of repeat ED cases for behavioral health. Scale targets will be implemented to mirror this progression throughout the five years of funding. Of note, there is currently no reliable way of measuring ED boarding times for psychiatric patients. The NQF measures of OP-18c has sample size issues for Maryland, which may unreliably skew performance. Over the next year, HSCRC staff will work with CRISP to develop an ADT-based measure of ED psychiatric boarding with industry input.

Overall Methodology:

1. RP Submits Participating Hospitals for Funding Stream Interventions
2. HSCRC Establishes Baseline Population in RP Hospitals' service area
    a. Crisis Services -- BH ED Utilizers as determined by CCS logic for Substance Abuse and Mental Health Flags PLUS CCW Substance Abuse ICD-10 procedure-based codes within Casemix
3. HSCRC Applies Evidence-based target to Baseline population (See Table Below)
4. HSCRC Establishes a target percentage for each Year of funding
5. HSCRC will report ongoing performance on all measures for RP tracking, targets will not change year over year

[18] Balfour, M. E., Tanner, K., Jurica, P. J., Rhoads, R., & Carson, C. A. (2016). Crisis Reliability Indicators Supporting Emergency Services (CRISES): A Framework for Developing Performance Measures for Behavioral Health Crisis and Psychiatric Emergency Programs. *Community mental health journal*, *52*(1), 1–9. doi:10.1007/s10597-015-9954-5
[19] Salkever, D., Gibbons, B., & Ran, X. (2014). Do comprehensive, coordinated, recovery-oriented services alter the pattern of use of treatment services? Mental health treatment study impacts on SSDI beneficiaries' use of inpatient, emergency, and crisis services. *The journal of behavioral health services & research*, *41*(4), 434-446.
[20] National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc. https://theactionalliance.org/sites/default/files/crisisnow.pdf

Crisis Services Scale Targets – Years 1-5

RP Year	*Target*	*Logic*	*Numerator*	*Num. Data Source*	*Denominator*	*Den. Data Source*	*Evidence-Based Target*
Crisis Services (Including Crisis Now and other Wrap Around Support Services) Scale Targets – Years 1-5							
1 through 3	Crisis Services Planning and Development	Each RP should show development of the Crisis Now component(s) indicated in their application	1. 5-Year Development and Business Plan for RP Crisis Services 2. MOUs with Community Partners, Member Hospitals and local emergency services (if indicated partners in business plan) 3. Crisis Protocols for Services indicated in application/award letter	RP Self-Report, HSCRC Audit	N/A	N/A	N/A
4	ED Boarding Times	As hospitals integrate Crisis Services into emergency operations, the ED wait times or boarding times for behavioral health patients should reduce.	Aggregate wait time for ED BH Cases as determined by CCS + CCW Flag Logic **WITH** An inpatient admission or observation stay	Casemix Integration with CRISP ADT Feeds	Aggregate wait time for ED BH Cases as determined by CCS + CCW Flag Logic **WITHIN** RP Hospitals	Casemix Integration with CRISP ADT Feeds	**To Be Developed with CRISP – will be released with funding notice**

5	ED Behavioral Health Repeat Utilization	Crisis Services should be established within the community for preventative ED utilization and outreach in addition to integration with other emergency services like police and EMS.	All ED BH Cases as determined by CCS + CCW Flag Logic **WITH** 3 or more ED visits in the past calendar year	Casemix	Total ED BH Cases as determined by CCS + CCW Flag Logic **WITHIN** RP Hospitals	Casemix	10% Reduction[21]

[21] Salkever D, Gibbons B, Ran X. Do comprehensive, coordinated, recovery-oriented services alter the pattern of use of treatment services? Mental health treatment study impacts on SSDI beneficiaries' use of inpatient, emergency, and crisis services [published correction appears in J Behav Health Serv Res. 2014 Oct;41(4):559]. *J Behav Health Serv Res.* 2014;41(4):434–446. doi:10.1007/s11414-013-9388-1.
https://pubmed.ncbi.nlm.nih.gov/24481541-do-comprehensive-coordinated-recovery-oriented-services-alter-the-pattern-of-use-of-treatment-services-mental-health-treatment-study-impacts-on-ssdi-beneficiaries-use-of-inpatient-emergency-and-crisis-services/?from_single_result=Do+Comprehensive%2C+Coordinated%2C+Recovery-+Oriented+Services+Alter+the+Pattern+of+Use+of+Treatment+Services%3F+Mental+Health+Treatment+Study+Impacts+on+SSDI+Beneficiaries%E2%80%99+Use+of+Inpatient%2C+Emergency%2C+and+Crisis+Services

Appendix D – Proposal Summary Template

As such, the applicants should provide short summaries with the most relevant points. Reviewers will rely on the more detailed Project Narrative for a more complete understanding of the proposal.

Hospital/Applicant:	
Hospital Members:	
Health System Affiliations:	
Funding Track:	
Total Budget Request:	

Target Patient Population
Proposed Activities

Measurement and Outcomes
Scalability and Sustainability
Governance Structure

Participating Partners and Financial Support List member hospitals/community collaborators and describe any resource sharing, financial support and/or in-kind support, if applicable.
Implementation Plan
Budget & Expenditures

Appendix E – Listing of Regional Partnership Collaborators

Please complete the following table for each Regional Partnership Collaborator. Create more tables, as necessary.

Name of Collaborator (1):	
Type of Organization: (i.e. LHIC, Non-Profit, LBHA)	
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	
Type and Purpose of Resource Sharing arrangements, if any	
Roles and Responsibilities within the Regional Partnership:	

Name of Collaborator (2):	
Type of Organization: (i.e. LHIC, Non-Profit, LBHA)	
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	
Type and Purpose of Resource Sharing arrangements, if any	
Roles and Responsibilities within the Regional Partnership:	

Name of Collaborator (3):	
Type of Organization: (i.e. LHIC, Non-Profit, LBHA)	
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	
Type and Purpose of Resource Sharing arrangements, if any	
Roles and Responsibilities within the Regional Partnership:	

Name of Collaborator (4):	
Type of Organization: (i.e. LHIC, Non-Profit, LBHA)	
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	
Type and Purpose of Resource Sharing arrangements, if any	
Roles and Responsibilities within the Regional Partnership:	

Appendix F - Budget Template

Hospital/Applicant:	
Regional Partnership Members:	
Funding Track:	
Total Budget Request:	

Workforce/Type of Staff	**Description**	**Amount**
IT/Technologies	**Description**	**Amount**

Wrap Around Services (that are not captured above)	**Description**	**Amount**
Other Indirect Costs	**Description**	**Amount**
Total Expenses & Investments		

Appendix G – Examples of Expense Not Covered

Examples of expenses that will not be covered under the Regional Partnership Catalyst Grant Program include:

- Electronic health records or patient hotlines or portals that are used for care delivery and communication unless specifically implementing systems or modules for diabetes and/or behavioral health activities.
- Investments to improve coding or documentation, including upgrades to systems to be compliant with regulatory changes such as ICD-10.
- All retrospective and concurrent utilization review.
- Fraud prevention activities.
- CRISP participation fees other than specific projects not otherwise available to all CRISP users.
- Any expenses for physicians that do not clearly related to diabetes and/or behavioral health crisis services (i.e., expenses for acquiring existing physicians that does not result in any change in access but simply results in the existing physicians being owned by the hospital).
- Any expenses that are primarily for marketing purposes unless these are specifically related to diabetes and/or behavioral health crisis services.
- Accreditation fees.
- Financial rewards to providers (e.g., pay-for-performance incentives). Programs however may use ROI for provider gain sharing and pay-for-performance incentives that are consistent with legal requirements.
- All other expenses that do not fall under the intent of the grant program.