Health Services Cost Review Commission
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Memorandum

To: Potential Applicants for the HSCRC Transformation Implementation Program

From: Steve Ports, SP Director, HSCRC Center for Engagement and Alignment

Date: November 13, 2015

RE: Extension of Submission Date for Transformation Implementation Program Request for Applications to December 21, 2015

The HSCRC has receive multiple requests from hospitals to extend the submission date of the Transformation Implementation Program applications for two weeks. In order to give more time to refine the proposals, we are therefore extending the submission date to December 21, 2015.

Please note that the reports of Regional Partnership Planning Grantees that received funding through rates in June 2015 are still due on December 7, 2015. Likewise, the Strategic Hospital Transformation Plans are due from all acute care hospitals on December 7, 2015.

Attached please find an updated Request for Proposal (RFP) for the Transformation Implementation Program. The changes are shown in red and only relate to the date of submission and the expected award date. Also attached is an updated Q&A which reflects the submission date change and incorporates recent inquiries regarding the RFP.

If you have any further questions, you may submit them to hscrc.rfp-implement@maryland.gov.

HSCRC Transformation Implementation Program
Request for Proposal

Updated November 13, 2015

The Health Services Cost Review Commission (HSCRC) seeks proposals regarding the implementation of plans to improve care coordination and population health in support of Maryland's All-Payer Model.

In 2014, the State of Maryland and the Center for Medicare & Medicaid Innovation (CMMI) reached an agreement to modernize Maryland's all-payer rate-setting system for hospital services. This initiative allowed Maryland to adopt new and innovative policies aimed at improving care, improving population health, and moderating the growth in hospital costs. Transforming Maryland's health care system to be highly reliable, highly efficient, and a point of pride in our communities requires increased 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.

Background

The State of Maryland is leading a transformative effort to improve care and lower the growth in health care spending through Maryland's All-Payer Model. Effective January 1, 2014, Maryland and CMMI entered into an agreement to modernize Maryland's unique rate-setting system for hospital services. This initiative aims to enhance patient care, improve population health, and lower total costs. HSCRC and DHMH envision a health care system in which multi-disciplinary teams including physicians and nurses, as well as individuals outside the medical model such as nutritionists, social workers, public health practitioners, community health workers, and religious leaders work with high-need/high-resource patients and their families to manage chronic conditions and address functional limitations and socioeconomic determinants of health. The All-Payer Model operates in conjunction with a number of other endeavors currently underway in Maryland, including efforts to strengthen primary care and coordinate hospital care with community care; map and track preventable disease and health costs; develop public-private coalitions for improved health outcomes; and establish Regional Partnerships.

While changes to hospital payment mechanisms consistent with the All-Payer Model are well underway, continued work and investments are needed to integrate and support the efforts of health systems, payers, community hospitals, independent ambulatory physicians, community providers, public health, and others to improve care delivery for patients. In accordance with the Budget Reconciliation and Financing Act (BRFA) of 2014, the Commission increased rates

on May 1, 2015 to provide up to $15 million for the purpose of funding the planning of regional partnerships throughout the State along with statewide infrastructure to support care management, coordination, and planning. During its June 2015 public meeting (see below), the Commission approved additional increases for all global budgets. Global Budget Revenue ("GBR") hospitals will receive an increase of 0.40% for infrastructure investments in FY 2016. DHMH and HSCRC are announcing an additional funding opportunity to improve care coordination and population health. The funds are intended to supplement related existing infrastructure initiatives. **C*ompetitive transformation implementation awards*** will be available to any Maryland acute care or specialty hospital (including TPR hospitals) that submits a successful bid. The aggregate amount available for these awards is up to 0.25% of statewide revenue, although the maximum amount a hospital may receive from multiple successful applications may not exceed 0.75% of the hospital's FY 2015 approved net patient revenue plus markup.

The ***competitive transformation implementation awards*** are intended to support and leverage a culmination of investments and activities related to partnerships, strategies, progress, and vision for care coordination and provider alignment in the State (See Appendix D for summary of care coordination investment and Timeline of related activities). The intent of these partnerships and strategies is to reduce potentially avoidable utilization at Maryland hospitals through better care coordination and provider alignment, which results in improvement on the metrics required under the new All-Payer Model. Those metrics include:

- Keeping the all-payer total hospital per capita revenue growth rate for Maryland residents below 3.58%;
- Achieving Medicare savings for Maryland beneficiaries in the amount of $330 million over 5 years compared to Medicare trend;
- Bringing the Maryland Medicare readmission rate to below the national average;
- Reducing Maryland Hospital Acquired Conditions in the State by 30% over 5 years; and
- Keeping Maryland Medicare per beneficiary growth over any two-year period at or below the national growth.

Awards are meant to build upon GBR infrastructure increases received in FY 2014 and FY 2015 and those plans being developed for the Regional Partnerships.

Hospitals interested in applying will be required to submit proposals describing how they will use these additional funds to work in collaboration with other hospitals, physicians, post-acute providers and other community based providers as well as patient and family advisory groups and organizations to improve care coordination and population health. Successful applicants will have care coordination and population health models underway and require additional infrastructure support to bolster immediate implementation of projects in the final stage of

planning, which will result in a positive return on investment, particularly through an early emphasis on high utilizers. The collective goal of these activities is to help support delivery system change with a focus on:

- Supportive services for persons living with chronic disease
- Long-term care and post-acute care integration and coordination
- Integration and coordination of physical and behavioral health services
- Support of primary care, particularly so that care plans and most medical services are well coordinated
- Identification, case management, and other supports for high needs and complex patients
- Episode improvements, including quality and efficiency improvements
- Patient-centered clinical consolidation and modernization to improve quality and efficiency
- Consumer and community engagement strategies aimed at improving patient and family-centered care and communication.
- Integration of community resources relative to social determinants of health and activities of daily living

Competitive transformation implementation awards are intended as an add-on to approved hospital rates. If awarded, enhanced GBR reporting will be expected. Activities will be monitored and measured to demonstrate how funds have been used to improve performance and show the impact that the related programs and interventions have on core outcomes.

Appendix A represents a sample of the type of metrics that may be required for reporting. Final reporting requirements will be issued following the award process.

Application Requirements and Timeline

Applications must be single-spaced, single sided, Calibri style and 11 point font size and submitted by the date below to hscrc.rfp-implement@maryland.gov. A review committee appointed by the HSCRC will review the applications. Funding guidelines and selection criteria, listed on page 4 and pages 8-10, respectively, will be used by the committee to recommend funding decisions.

- Funding announcement: August 28, 2015
- Application deadline: December 21, 2015, 11:59 pm
- Anticipated award announcement: February 2016

Sections 1-6 and 8-9 of the Narrative must be submitted in Word or similar formats.

Section 7 of the Narrative (Implementation Work Plan) must be submitted in a PDF of Microsoft Excel or a common project management software, such as Microsoft project.

Contact Information

During the application process, questions and answers will be posted on the HSCRC website. Additional questions may be submitted to:

Steve Ports
Director, Center for Engagement and Alignment
Maryland Health Services Cost Review Commission
Phone: (410) 764-2591
Email: hscrc.rfp-implement@maryland.gov

Eligibility Criteria

Applications for a competitive transformation implementation award may be submitted by:

- An individual hospital
- Multiple hospitals as lead applicants
- A hospital participant from a regional partnership as a lead applicant applying on behalf of a regional partnership

All applications ***must*** include (in addition to the lead hospital or hospitals) collaborating providers, physicians, or other community based organizations. Applications that include a broad and meaningful network, including patient and consumer representatives, will receive additional points when scored.

A hospital may participate in multiple applications as a single entity or as part of a Regional Partnership or other collaboration. Each application will need to demonstrate how plans and resources complement one another. Applications must be able to describe how they are distinct from one another and, if there is overlap, identify where overlaps exist and where there is distinction with respect to return on investment (ROI) and the budget.

There is no limit to the number of applications in which any one hospital may participate. The maximum total dollars that may be awarded to a hospital for a single application is 0.5% of the hospital's FY 2015 approved net patient revenue plus markup. There may be multiple lead hospitals in an application and the maximum award for each of those lead hospitals is 0.5%. However, an individual hospital may be awarded up to a total of 0.75% of its FY 2015 approved net patient revenue plus markup for a combination of multiple successful applications.

The State reserves the right to make awards based on applications received and will determine how funds are dispersed. This means that:

- Determinations by the review committee and HSCRC are final and not subject to appeal;
- The HSCRC may suggest alterations to the scope or amount of a proposal during the process;

- The HSCRC may require an applicant to alter a proposal or proposals to come into compliance with the award limitation described above.

Funding and Budget Guidelines

Consistent with existing law, applications will be required to clarify how funds will be distributed and flow to collaborating hospitals, providers, physicians or Community-based Organizations (CBOs). If more than one hospital applies as a lead applicant, the application and budget must clarify if:

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

Awarded funds will be collected by the hospital through rate increases in Rate Year 2016. It is expected that Rate Year 2016 awards will be expended within CY 2016.

Applicants will be expected to calculate the annual Return on Investment (ROI) for the funds. The HSCRC expects that a portion of the ROI accrue to payers. Applicants are expected to show how the ROI will be apportioned between the hospital(s), and payers and how the payer portion will be applied (global budget reduction, etc.). Applicants are also expected to demonstrate how the program/intervention is helping Maryland meet the goals and requirements of the All-Payer Model agreement with CMMI. Given that these awards are intended to build on and leverage previous infrastructure investments, the ROI should include the incremental impact of this particular funding with all investments made in mind. The ROI is intended to sustain successful programs into the future by encouraging continued alignment between hospitals and other providers. While award dollars may not be used for provider incentive programs (such as pay-for-performance), ROI may be utilized to support such programs, provided of course, that they are permissible under State and Federal Law.

The proposed budget is expected to demonstrate the applicant's ability to execute the intervention, to the extent practicable, within CY 2016. In addition, the budget should clearly detail how funds will flow to all partners included in the application.

Narrative Requirements

The narrative describes your project. It consists of sections 1-6 immediately below and may not exceed 20 pages.

1. **Target Population**
   This section must define the geographic scope of the model via a comprehensive list of the ZIP codes included, as well as counties and incorporated cities. Additionally, data

and a corresponding narrative should be used to describe the health need(s) and condition(s) that the delivery model will address within the proposed geographic area. Applicants are required to utilize existing Community Health Needs Assessments (CHNAs) or other related documents to describe the health need.

2. **Proposed Program or Intervention(s)**

   This section must include a description of the proposed delivery/financing model(s) to be implemented or enhanced. 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 infrastructure (e.g., analytics) and workforce that are needed to support the model. The discussion of the proposed program or intervention should be very specific and describe how programs, interventions, and resources, complement other programs/interventions underway based on previous infrastructure investments being pursued by an individual hospital as part of a Regional Partnership or other collaboration. Also, include a description of how they are distinct from one another and, if there is overlap, clarify how they intersect.

   While the program/intervention itself should focus on particular patient populations, such as patients with multiple chronic conditions and high resource use, the proposal should describe how the program/intervention will improve population health. The proposal should also describe how the model of intervention fits within your overall hospital strategic transformation plan.

3. **Measurement and Outcome**

   This section should describe how progress on the program, model or intervention be measured. The section should describe the expected outcomes and include baseline data and measures. Appendix A - Tables 1 and 2 are a guide for types of measures that the Commission considers necessary for success on the All-payer Model requirements. In addition to high level goals that the applicants are pursuing, specific program-specific measures should be proposed by applicants. Applicants should provide the evidence basis for their approach.

4. **Return on Investment**

   This section should describe specifically how the proposed program or intervention will move toward meeting the goals and requirements of the new All-Payer Model in Maryland. The expected hospital ROI for Rate Years 2017, 2018, and 2019 must be quantified (see Appendix A -Table 3 for an example and a blank template). Plans for utilizing the ROI retained by the hospital or partnership must also be specified and by

when. In addition to the ROI for the participating hospitals, the HSCRC expects that a portion of the ROI accrue to payers. Applicants are expected to show how the ROI will be apportioned between the hospital(s), and payers, and how the payer portions will be applied (global budget reduction, etc.).

If the model or intervention is expected to reduce the total cost of care beyond the hospital, please quantify expected savings.

5. **Scalability and Sustainability**

   This section should detail how the intervention/program is sustainable without additional rate increases in future years (beyond the ongoing amount associated with this competitive award). 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 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 use a project management software such as Microsoft Project™ or other equivalent program)**

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

8. **Budget and Expenditures**

   This section should include a line item budget, using the template in Appendix D.

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

   This section should include a brief narrative justifying the expenses. Funds should be used for implementation activities. If the proposal includes multiple interventions, please show the budget for each intervention separately. Funds should be used for implementation activities. Examples of ineligible expenses are described in Appendix B.

   Funds awarded are intended to leverage or build upon transformation plans or existing investments made for specific programs designed to meet the State's goals and

requirements of the All-Payer Model agreement with CMMI, and improve population health.

This section shall include the percentage of the total investment of the program, model, or intervention is covered by the award, and the source of other funding to support the program, model, or intervention.

Total dollars awarded to a hospital acting as a single entity are capped at 0.5% of the hospital's FY 2015 net patient revenue plus markup. Total combined awards to a hospital through single entity applications, regional partnership applications, and multiple hospital applications are capped at 0.75% of the individual hospital's FY 2015 net patient revenue plus markup.

Investments included in the budget should have the potential to impact population health within the communities that each hospital, regional partnership, or collaboration serves. Investments included in the budget are expected to be data driven and able to be evaluated using measurable outcomes.

10. Summary of Proposal (2-3 Pages)

Applicants are required to summarize their proposal in a standard format. See Appendix C for the required summary format table. Complete one summary table delineating differences for each intervention in each category, if applicable.

Selection Criteria

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

1) Appropriateness of the Target Population in terms of the potential to positively impact key outcome measures
2) Whether the program, model, or intervention is well-conceived, evidence-based, and appropriately proposes to use infrastructure and workforce in an efficient and effective manner to improve care coordination, physician alignment, and health outcomes of the target population.
3) Consistency with All-Payer Requirements: Support the purpose of All-Payer Model. Positive results on the metrics in Appendix A would be seen as supporting the All-Payer Model.
4) Consistency with the participating hospital(s) strategic transformation plans submitted to the HSCRC on December 1, 2015 and consistency with other investments, including prior GBR infrastructure investments.
5) Results and Efficacy of Investment(s) to date.
6) Whether investments being proposed complement rather than duplicate state and regional resources

7) The extent to which the program, model, or intervention innovatively uses health information technology (telehealth, electronic health records, health information exchange) to improve care, create efficiency in care delivery, and reduce costs. The extent to which the program, model, or intervention supports alignment and the use of information across hospitals, physicians, post-acute care providers, and other community based providers with the goal of improving the delivery of care in a manner that achieves the core outcome measures outlined in Appendix A.
8) Patient-Centered: The extent to which the proposed interventions support patient-centered care delivery, meaning they demonstrate how the care coordination efforts flow among different providers for high risk patients using different hospitals and how the structures and efforts will have tailored technologies and methods to address patient and family preferences and engagement in their care. The extent to which consumer perspectives, engagement, communication, and outreach, are included in models.
9) The feasibility for a reasonable ROI in Fiscal Years 2017, 2018, and 2019 that allows for sustainability over time. The apportionment of ROI to payers. The potential to reduce the total cost of care including both hospital-based and nonhospital-based health care costs.
10) Implementation Plan: Level of detail and feasibility of implementation plans
11) Budget: The reasonableness and adequacy of the proposed budget. A clear description of how awarded funds will be dispersed to organizations and providers included in the application consistent with existing law.

Appendix A

Table 1. Core Outcome Measures

Measure	Definition	Source	Population(s) expected
Total hospital cost per capita	Hospital charges per person	HSCRC Casemix Data	All population for covered zips, high utilization set, target population if different, each by race/ethnicity
Total hospital admits per capita	Admits per thousand	HSCRC Casemix Data	All population for covered zips, high utilization set, target population if different, each by race/ethnicity
Total health care cost per person	Aggregate payments/person	HSCRC Total Cost Report	All population for covered zips, high utilization set, target population if different, , each by race/ethnicity
ED visits per capita	Encounters per thousand	HSCRC Casemix Data	All population for covered zips, high utilization set, target population if different, , each by race/ethnicity
Readmissions	All Cause 30-day Readmits (see HSCRC specs)	CRISP	High utilization set, target population if different, each by race/ethnicity
Potentially avoidable utilization	(see HSCRC specifications)	PAU Patient Level Reports	High utilization set, target population if different, each by race/ethnicity
Patient experience	% rating 9 or 10	HCAPHS	High utilization set, target population if different, each by race/ethnicity

Table 2. Core Process Measures

Measure	Definition	Source	Population(s) expected
Use of Encounter Notification Alerts	% of inpatient discharges that result in an Encounter Notification System alert going to a physician	CRISP	All population for covered zips, high utilization set, target population if different
Completion of health risk assessments	% High utilizers with completed Health Risk Assessments	Hospital, Partnership, Collaboration	High utilization set, target population if different
Established longitudinal care plan	% of High Utilizers Patients with completed care	Hospital, Partnership, Collaboration	High utilization set, target population if different
Shared Care Profile	% of patients with care plans with data shared through HIE in Care Profile	CRISP	High utilization set, target population if different
Portion of target pop. with contact from assigned care manager	% of High Utilizers Patients with contact with an assigned care manger	Hospital, Partnership, Collaboration	High utilization set, target population if different

Table 3. Core Return on Investment Measures

ROI = G (variable savings) ÷ D (annual intervention)
Proposed Savings of 15%
ROI should be greater than 1 at steady state operations (and get there early)

Illustration	High Utilizers ≥ 3 IP Admits	High Cost Top 10%
A. Number of Patients	40,601	136,601
B. Number of Medicare and Dual Eligible	27,000	79,000
C. Annual Intervention Cost/Patient	$3,500	$3,500
D. Annual Intervention Cost (B X C)	$95M	$277M
E. Annual Charges (Baseline)	$1.9B	$3.8B
F. Annual Gross Savings (15% X E)	$280M	$570M
G. Variable Savings (F X 50%)	$140M	$285M
H. Annual Net Savings (G-D)	$45M	$8M

Template to complete:

ROI = G (variable savings) ÷ D (annual intervention)
ROI should be greater than 1 at steady state operations (and get there early)

Hospital/RP Name:	Target Population
A. Number of Patients	
B. Number of Medicare and Dual Eligible	
C. Annual Intervention Cost/Patient	
D. Annual Intervention Cost (B x C)	
E. Annual Charges (Baseline)	
F. Annual Gross Savings (XX% x E)	
G. Variable Savings (F x 50%)	
H. Annual Net Savings (G-D)	

XX% is proposed savings from the proposed strategy(s)

Appendix B

Examples of expenses not covered include:

- Electronic health records or patient hotlines or portals that are used for care delivery and communication unless specifically implementing systems or modules for care coordination activities (e.g., electronic health record module for care manager to record activities or patient portal for contacting care manager).
- Most billable services (this does not include Chronic Care Management (CCM) payments). This means that expenses could be used to enable physicians to access CCM payments.
- Investments to improve coding or documentation, including upgrades to systems to be complaint 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 increase access to primary care or other healthcare 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.
- 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 care coordination and population health.

Appendix C Proposal Summary

Reviewers will use appendix C as a reference guide. 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:	
Date of Submission:	
Health System Affiliation:	
Number of Interventions:	
Total Budget Request ($):	

Complete the summary table delineating differences by intervention for each category, if applicable.

Target Patient Population (Response limited to 300 words)
Summary of program or model for each program intervention to be implemented. Include start date, and workforce and infrastructure needs (Response limited to 300 words)
Measurement and Outcomes Goals (Response limited to 300 words)

Return on Investment. Total Cost of Care Savings. (Response limited to 300 words)
Scalability and Sustainability Plan (Response limited to 300 words)
Participating Partners and Decision-making Process. Include amount allocated to each partner. (Response limited to 300 words)

Implementation Plan (Response limited to 300 words)
Budget and Expenditures: Include budget for each intervention. (Response limited to 300 words)

Appendix D Budget Template and Narrative

Hospital/Applicant:	
Number of Interventions:	
Total Budget Request ($):	

Complete the budget table below, listing each type of budget line item, narrative summary description for each, and amount of expenses estimated.

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

Other implementation Activities	Description	Amount
Other Indirect costs	Description	Amount
Total Expenses/investments		

Appendix E

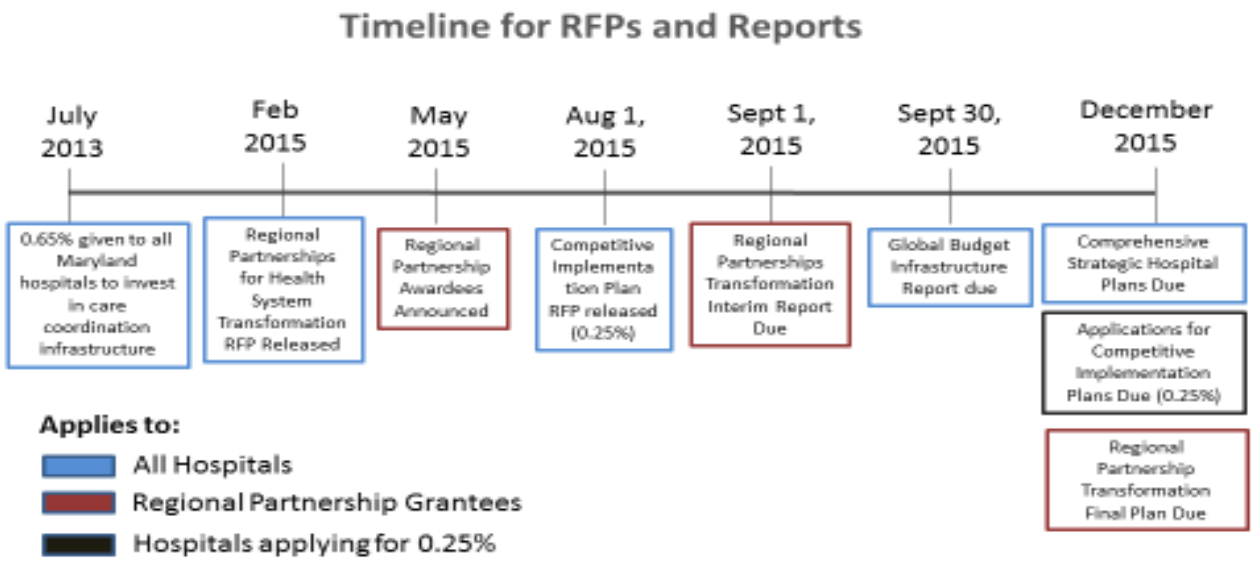
Summary of Support for Care Coordination Investment

In Fiscal Years 2014 and 2015, the Commission, recognizing the need for seed funding to invest in best practices to improve care coordination activities, increased most GBR hospital's rates by a total of 0.65%, with the intent of it being used to invest in infrastructure that promotes the improvement of care delivery and reductions of potentially avoidable utilization. This funding was approved by the Commission to support the transformation with the expectation that the real return on investment will occur if projects are focused and well executed. TPR hospitals have been provided even higher levels of funding on a proportional basis. On September 30, 2015, all hospitals are required to submit a GBR Investment Report to HSCRC on the amounts and types of investments they have made and will make to improve population health, and how effective these investments are in reducing potentially avoidable utilization and improving population health.

In accordance with the provisions of the State Budget Reconciliation and Financing Act of 2014 (BRFA), earlier this year, the Commission increased rates (in FY 2015) effective May 1, 2015 to provide up to $15 million for the purpose of funding the planning of regional partnerships throughout the State; and statewide infrastructure to support care management, coordination, and planning. In preparation for this funding, in February 2015, DHMH and HSCRC released an RFP to all hospitals offering funding to support the planning and development of *Regional Partnerships for Health System Transformation*. A portion of the BRFA funding ($2.5 million) was awarded to hospitals who applied for the funding to support regional planning and development initiatives with key community partners. A multi-stakeholder review committee selected 8 of 11 proposals; funding ranged from $200,000 to $400,000. Those grantees are required to submit a final Regional Transformation Plan to DHMH and HSCRC on December 21, 2015.

During its June 2015 public meeting, the Commission approved additional increases to the global budgets of GBR hospitals for FY 2016 to continue successful investments in infrastructure. All global budgets of GBR hospitals will receive an increase of 0.4% for infrastructure investments. Separately, an additional 0.25% in competitive transformation implementation awards will be available to hospitals, working in collaboration with other hospitals, physicians, post-acute providers and other community based providers. Hospitals interested in applying will be required to submit proposals describing how they will use these additional funds for implementation of developed strategies to improve care coordination and population health. The Commission is releasing a Request for Proposals (RFP) and proposals will be due on December 21, 2015.

The Commission also approved a recommendation that will require all hospitals to submit multi-year strategic plans for improving care coordination, chronic care, and provider alignment. These plans will be due on December 7, 2015. The strategic plan should draw from the other required reports and demonstrate how strategies are aligned. All hospitals will be required to submit their own strategic plan; however, in areas where hospitals are working with one another through a Regional Partnership or other collaborations, they should reference their Regional Partnership Transformation Plan.



Summary of HSCRC Required Reports:

Submission	Associated Funding	Report Due Date	Requirements/ Scope	Who
Interim Regional Transformation Report from Regional Partnerships	$2.5 million (BRFA funding)	September 1, 2015	Interim Regional Transformation Plan Template (draft shared with grantees)	Regional Partnership Grantees
Global Budget Infrastructure Report	0.65% given to most GBR hospitals in July 2013/2014 *TPR hospitals were provided additional funding 0.4% increases approved for FY2016 for all GBR hospitals	September 30, 2015	GBR Infrastructure Report Template available on HSCRC website	All Hospitals

Final Regional Transformation Report from Regional Partnerships	$2.5 million (BRFA funding)	December 7, 2015	Regional Transformation Plan Template (draft shared with grantees)	Regional Partnership Grantees *Partnering hospitals will collaborate on one final report
Strategic Hospital Transformation Plan for Improving Care	N/A	December 7, 2015	Similar template as Regional Transformation Plan only broader and more comprehensive in scope	All Hospitals *Plans should refer to and align with GBR Infrastructure Report, Regional Partnership Plan (if applicable), Community Benefit Report and Community Health Needs Assessments
Applications/ Proposals for Competitive Transformation Implementation Awards	0.25% (approx. $40 million)	December 21, 2015	Applications should draw from multi-year strategic hospital plan; must demonstrate how investments build on one another	All Hospitals are Eligible to Apply *Collaboration among hospitals in a single application is encouraged and collaboration with physicians and other providers is required. RFP will provide more details when released.

Other Required Reports:

Submission	Associated Funding	Report Due Date	Requirements/Scope	Who
Community Benefit Report	N/A	December 15, 2015	Template available on the HSCRC website	All Hospitals
Community Health Needs Assessment	N/A	Hospitals on 1-3 year cycle	Hospitals should follow federal CHNA requirements	All Hospitals

Technical Assistance Available to All Hospitals

In an effort to support the Regional Partnership Grantees through the process of establishing their plans for regional partnerships, the State, in collaboration with the Chesapeake Regional Information System for our Patients (CRISP), has assembled technical resources and consultants with broad experience and expertise in similar initiatives around the country. A portion of the statewide infrastructure funding is being used to provide this technical assistance support to the planning grantees and all hospitals and their partners throughout the State as they work their way through essential delivery system transformation. While planning grantees may avail themselves of one-on-one consultation (up to 60 hours) all hospitals and their partners will be invited to participate in a series of bi-monthly, topic-specific webinars and an interactive Learning Collaborative on specific topics of interest that will be designed to assist hospitals and their partners as they endeavor to improve their care coordination with the goal of real delivery system reform. Specific webinar topics will be sent closer to the meeting date; your input into the content of these events is encouraged. Please refer to the DHMH website for an updated list of webinar topics and resource material:
http://pophealth.dhmh.maryland.gov/transformation/SitePages/Home.aspx

A schedule of these events and opportunities are as follows:

- Webinar: Consumer Education and Outreach: September 10, 9-10am EST
- Webinar: Behavioral Health Integration Models: September 24, 9-10am EST
- Learning Collaborative: October 1, 9-10am EST
- Webinar: Topic TBD: October 8, 9-10am EST
- Webinar: Topic TBD: October 22, 9-10am EST
- Webinar: Topic TBD: November 12, 9-10am EST

FAQs – HSCRC Transformation Implementation Program RFP

Updated November 13, 2015

Q: How are the permanent rate increases going to work?

A: We expect that whatever is awarded would be expended through the end of the calendar year 2016. The amount awarded would be continued in rates indefinitely but the Commission will reserve the right to make adjustments in future years if funds are not being used as intended or initiatives fail to meet expected goals. For the regional planning grants, the award amount was included in rates for one year and will then be removed in following years. The implementations grants will not be removed (barring any adjustments made by Commission staff if expectations are not met) and will be in hospitals' rate bases and global budgets permanently.

Q: For the Regional Partnerships, what are the expectations about how the hospitals will share the funds?

A: Hospitals will need to submit the details in the budget about how the money would be shared. While distributions may change in future years, the partnership must demonstrate continued appropriate collaboration and sharing of resources.

Q: Can the RFP be used in lieu of the final Regional Partnership Transformation plan due Dec. 1?

A: No, both will need to be submitted, however, the RFP should reference and use information from the Regional Partnership Transformation plan in the RFP. We are attempting to reduce the burden of the multiple reports for the Regional Partnership grantees by incorporating those final reports into a same or similar template as the Strategic Transformation Plans. Note that the due date has been moved to December 7, 2015 for the submission of the regional partnership report. And the application date for Transformation Implementation grants has been extended to December 21, 2015.

Q: On one slide a discussion point was the understanding and working with social resources. Are you considering in the RFP awards that all counties are not provided the same state dollars for the health departments? These health departments are lacking equivalent social programs that our Partnerships have to provide, which can be costly. Shouldn't local Health Departments be budgeted in a like manners throughout Maryland and not use our GBR?

A: While this question goes beyond the scope of this RFP, the review committee will be considering proposals on the extent to which they can reduce avoidable utilization, reduce costs, and increase quality. Where there is a void in care coordination which results in an increase in the use of inpatient services particularly for chronic illnesses, there may be opportunity.

Q: If we are not meeting our goals and proposed outcomes would the rates be adjusted back down?

A: If this happens we anticipate having individual conversations with that hospital or partnership to try and help them meet their goals. However, if over time the hospital is still not meeting their goals and proposed outcomes, HSCRC reserves the right to make rate adjustments accordingly.

Q: Does the proposal need to be in the exact order as laid out in the RFP? Do the headings need to be the exact same?

A: Yes, please follow the format detailed in the RFP.

Q: Can you be more specific about the expectations for apportioning of ROI to Payers?

A: Under global budgets, most of the financial benefits of reduced utilization will accrue to the hospital. The clear expectation is that those resources would be shared among the partners identified in a proposal. Under this scenario, the public is directly benefited on two of the three pillars of the Three-Part Aim - better care and better health. In terms of reduced costs, the overall system (payers, patients, etc.) benefit by a reduction in the historical growth of hospital revenue in the State. Under global budgets however, patients and payers on a per-case basis may pay more as utilization is reduced. The Commission has specifically directed staff to ensure that there are savings to the Payers as a result of awards being made through this RFP. The most direct way to do that for all-payers is through an overall reduction in a hospital's global budget. However, more targeted approaches may be considered. A reduced cost in uncompensated care attributable to a proposed model, for example, would represent a payer savings.

Q: How do you advise we predict ROI for years beyond 2017 when implementation will not start until 2016?

A: The Commission expects a continued ROI into the future, especially since the dollars are permanently in rates. This should be explained in your plan for sustainability.

Q: Explain what you mean by reasonable ROI?

A: The Evaluation Committee will define what reasonable ROI is after reviewing the proposals. A base level ROI would be one that would sustain the initiative.

Q: References to assuring that the scope of the application complements but does not duplicate state and regional programs and resources. Could you please provide further clarification / reference material?

A: The Care Coordination Work Group report identified the role of state-wide infrastructure to support hospitals, providers, and other partners as they work toward improving care coordination. It is important that these initiatives do not duplicate the efforts that are being taken to support the infrastructure through CRISP and other means. It would not be prudent for all hospitals to build separate infrastructure and tools if they are available to all providers on a statewide level. Moreover, if there is funding currently available for a proposed initiative, it is not intended for rate dollars to supplant that resource.

Q: Can you further clarify the budget line items (explain what is permitted or not permitted in indirect costs for example)?

A: Indirect costs are those for activities or services that benefit more than one project and primarily a project that is not named in the proposal. Indirect costs could include costs related to administrative services that are budgeted under another function of the hospital or unit working on this initiative. Indirect costs may be listed in broad categories (overhead, shared administrative staff, etc.), and for

each category the applicant may include a percentage of the proposal amount that the indirect costs represents (under description). The right column would identify the total dollar amount for each broad category.

Q: Is the scope and associated work plan for this application to cover only the work that will be performed during CY2016? Or, since the rate adjustments continue in subsequent years, are we to include work in subsequent years and relate that to the ROI for those years?

A: The proposals should be specific about the CY 2016 work plan. The work plan should also include, more generally, how the work plan will flow into future years, particular if the initiative is to be expanded or altered in the future.

Q: Can HSCRC expand on the expectation for "enhanced GBR reporting"? Does that mean that each hospital will report individually on the activities of the RP or will there be some reporting requirements for the RPs? If there are any additional reporting requirements for the RPs, please outline what those are.

A: The regional planning (RP) grant report is a separate report from the GBR. The Regional Planning Grantees are required to report on their plan on December 7. No other reports are required after that for the Regional Planning Grantees. All hospitals will be submitting GBR reports annually which will provide an overview of how hospitals have utilized their infrastructure support provided in rates. The GBR report will likely be enhance for Implementation Grant Awardees so that we may track use of the awards and monitor outcomes and impacts.

Q: Where did the 15% number come from in Table 3 and the following template?

A: The 15% was an example of an expected savings. Proposals should include an expected percentage savings amount that is justified in the application. If the expected savings do not come to fruition, the Commission reserves the right to make adjustments to the permanent amount in rates in the future.

Q: Appendix B states that financial rewards to providers such as pay-for-performance incentives are not covered. Can HSCRC explain how this reconciles with the expectation to align with other providers?

A: Awards may not be used for provider incentive programs. If a hospital wishes to utilize provider incentives, it may use ROI resulting from this initiative or other related initiatives to support such programs provided that the incentive program meets all requirements of State and Federal Law or any applicable waivers. The Commission is currently working to see if waivers are attainable from applicable laws that are barriers to such incentive programs. If such waivers are obtained, the Commission and MHA will notify the hospital industry.

Q: Please clarify the instructions to "complete the summary table delineating differences by intervention for each category." If several interventions are planned, should the table be completed for each intervention or should all the interventions be summarized into a single the table?

A: All interventions should be summarized in a single table. If there are 5 interventions, for example, please number each initiative in each box – 1., 2., 3., etc. Item #1 in each box would refer to the same initiative. This is meant as a very succinct summary of the narrative.

Q: Could HSCRC provide more language to any expectations of these partnerships as it relates to the implementation awards?

A: Additional language has been added. The list of areas of focus on page 3 of the initial draft provides detail on expectations.

Q: The application deadline is listed for December 1, 2015. Given the many other deliverables due December 1st (e.g. 3 year strategic plan and the plan related to the regional partnerships) and the Thanksgiving Holiday occurring immediately before, can the HSCRC consider pushing this timeline back?

A: Yes. The Commission has extended the date of the submission of the transformation implementation grant applications to December 21, 2015

Q: Within the Eligibility Criteria section it states "Applications that include a broad and meaningful network will receive additional points when scored". Can HSCRC be more specific as to how many additional points will be given?

A: Points will be awarded in the context of how well the model will meet the goals of the All-Payer model and to the extent to which it will elicit improvement on the metrics in Tables 1 and 2. In order to achieve this goal a meaningful set of partners would be needed. The review committee will determine how many points it will award for item #6 under the narrative section.

Q: Within the Eligibility Criteria section it states "The State reserves the right to make awards based on applications received and will determine how funds are dispersed". Can HSCRC clarify what this means; is there an additional process in addition to what is described in the RFP?

A: This clarifies that the amount awarded by the Commission is the final amount and not subject to further review or appeal. It is possible, after review, a hospital would receive multiple award amounts that would exceed the award limitation outlined in the RFP. The State would reserve the right to have a conversation with the applicant and to work out changes to proposals to bring a hospital or hospitals in compliance with the limitation. This verbiage also clarifies that the Commission may either deny funding an application, or suggest a reduction in the proposed amount or scope of a proposal.

Q: The page limit for the application is 20 pages. Can appendices be used and if so will they count towards the total page count?

A: Yes, judicious use of appendices is permitted and will not count toward the page limitation.

Q: HSCRC is using a variable savings percentage of 50%. JHHS believes that the number could vary depending on the type of patient. Some types of cases have much higher variable cost factors than others. The variable savings percentage should be based on actual data and not assumed to be 50%.

A: The Commission's variable cost factor policy is 50% meaning that hospital utilization reductions could reasonably expect to "free up" 50% in the short run with the remaining be fixed costs. However, those fixed costs could be eliminated overtime as well. When addressing total cost of care savings, a different percentage may be calculated and justified, so customized variable cost factors may be used in the template.

Q: With regards to the ROI calculation, is HSCRC only looking at hospital charges/cost or is it total cost of care?

A: Since the investment is primarily supported through hospital rates the HSCRC is most interested in the hospital ROI. However, in addition it is important to show any total cost of care savings from the initiative. Under the agreement with CMMI, the current All-Payer Model will be transitioning to a total cost of care. The HSCRC will be interested to understand how an applicant's initiative might progress toward this transition. So hospital ROI is required in the template. However, if a total cost of care ROI can is justifiable, then the review committee will likely find this of particular interest.

Q: If a region develops a regional partnership that several hospitals are participating in, should a single response be submitted by all the participating hospitals or should all the hospitals participating in the regional partnership project submit the identical proposal?

A: The participating hospitals should submit one proposal. It should be determined however whether the funding should be provided through one of the hospital's rates, several of the hospital's rates, or all of the participating hospital's rates. A hospital may be a partner without being the "lead" hospital from which the rates will be accessed.

Q: Does a project need a defined lifespan? Be for a minimum amount of time?

A: It is expected that a project positively impact the key metrics identified in the RFP over a longer term period of time. With the eventual transition of the New All-Payer Model to a total cost of care model, an approved initiative, model, or program will be expected to continue to improve quality of care into the future and have a greater focus on reducing costs on a total cost of care basis. So while expenditures are expected to be made in CY 2016, the program should be multi-year with a greater future focus on total cost of care savings.

Q: Clarify the .75% combined grant limit

A: No award may for a single application may increase rates of a hospital by more than 0.5% of the individual hospital's FY 2015 approved net patient revenue plus markup. However, if a hospital is involved in other successful awards as a lead applicant, the cumulative maximum that may be placed in that hospital's rates is 0.75% of the hospital's FY 2015 approved net patient revenue plus markup.

Q: We want to know at a maximum can our regional partnership propose an initiative that is funded at 0.75% of the total FY 2015 revenue plus markup or are we limited to 0.50%. Since the RFP materials describe 0.50% as the maximum for any "one" proposal?

Since there has been some confusion about this section, the Commission has amended the language for clarity. The two relevant sections of the application now read as follows:

"The aggregate amount available for these awards is up to 0.25% of statewide revenue, although the maximum amount a hospital may receive from multiple successful applications is 0.75% of the hospital's FY 2015 approved net patient revenue plus markup."

"There is no limit to the number of applications any one hospital may participate in. The maximum total dollars that may be awarded to a hospital for a single application is 0.5% of the hospital's FY 2015 approved net patient revenue plus markup. However, an individual hospital may be awarded up to a

total of 0.75% of its FY 2015 approved net patient revenue plus markup for a combination of multiple successful applications."

Q: May a hospital submit multiple applications that, if all successful, would exceed the 0.75% maximum as described above?

A: Yes and if all were considered favorable by the review committee, the hospital(s) would need to submit revised applications to reduce the total amount to the required maximum level of funding through rates (0.75%).

Q: What is meant by a "lead" applicant?

A: A lead applicant is a hospital applicant from which rates are proposed to be increased to support the proposal.

Q: Can we tell you how much we want from each hospital, as an example: 0.25% from Hospital A, 0.50% Hospital B, 0.40 from Hospital C, etc...?

A: Yes

Q: We are under the impression that activities that support the "transformed model of care" that have been implemented prior to January 1st would not be eligible for implementation grant funding (part of the $40M). Purely for example, imagine that a hospital had agreed to share a care management platform and installed the software in October. The use of this platform could be extended to the community partners to aid in gathering more "real time" data to support care management and coordination by any stakeholder group involved with this patient. This extension would be part of the transformation planning final report. Could our implementation grant application include the cost of the software which would extend to partners, even though the initial implementation occurred prior to January 1st?

A: If the implementation project extended the initiative beyond its existing focus and meet the criteria identified in the application it could be considered for funding under the process. However, if funding has already been designated for the expansion or extension, these dollars could not be used to replace those dollars.

Q: What if the Coalition doesn't spend the entire grant dollars in the year? Does it carry over?

A: Commission staff would review the facts circumstances as they arise and will address such issues at that time.

Q: Once a hospital is awarded an Implementation Grant, and it performs well, can it change its focus in future years as it sees other opportunities to meet the same goals of Triple Aim?

A: Commission staff would review the facts circumstances as they arise and will address such issues at that time.

Q: Will there be a bidders conference.

A: No. We are using this process to respond to questions, to which all hospitals and partners have access to.

Q: What are the formatting expectations for the budget narrative? Other than the three page limit, how should it differ from the budget per Appendix D in the RFP (which requires narrative descriptions)?

A: Applications must be single-spaced, single sided, Calibri style and 11 point font size, including Appendix D.

Q: Can you clarify what is meant by the following bullet points? These are part of a bulleted list on page 3 of the RFP. "Episode improvements, including quality and efficiency improvements" – How is "episode" defined in this context? "Patient-centered clinical consolidation and modernization to improve quality and efficiency" – How is "clinical consolidation and modernization" defined in this context?

A: These are intended in the broadest sense and may be considered differently by hospitals. It is intended that where episode improvement can improve quality and efficiency of care and the transitions of care and reduce potentially avoidable utilization, it should be a consideration. As for clinical consolidation, this refers to better coordination of care that addresses the needs and desires of the patient.

Q: Can expenses for the delivery of direct medical services delivered outside the hospital system? If so, can funds be used to pay directly for services or would there need to be a structure in place (e.g., a common wellness fund managed collaboratively by the hospitals) to deliver the services?

A: Please specify the arrangement in the application but this application does not restrict such use of the funding. You should ensure that such an arrangement does not violate and State or Federal law however.

Q: Would you be able to define "markup"?

A: "Markup" is the amount included in hospital rates that includes uncompensated care costs, and the payer differential. The hospital's finance office will be able to calculate the markup.

Q: If multiple hospitals significantly participate in an application, can each of them get the 0.5% revenue base or is the 0.5% limited to only the lead applicant? Can there be multiple lead applicants, or is the lead applicant only one hospital?

A: There may be multiple lead hospitals in an application. A lead applicant is a hospital who is requesting dollars through their rates. There may be other partnering hospitals in an application that are not requesting dollars through rates (they are not a lead hospital). The maximum award allowance is 0.5% for each lead hospital on an application. Language has been added on page 4 of the Request for Proposals to clarify this.

Q: The implementation RFP asks for a line item budget and expenditures narrative for calendar year 2016. It also asks for expected ROI for rate years 2016-2019 and then the feasibility of reasonable ROI in fiscal years 17-19. Is there any way that we can try to align the financial processes so we are working off of a hospital fiscal year or do we just need to do that internally with the hospital?

A: It is preferable to show both on a Calendar Year basis since the All-Payer Model metrics are based on a calendar performance year. In addition, this grant is for programs that are prepared to achieve results and ROI immediately. Since grants will be provided close to the beginning of the CY, we would like to see the immediacy of the expected outcomes and return.

Q: ROI calculation template has a line item for the number of Medicare and Dual Eligible patients. Can you confirm that those patient populations should be separated to distinguish between the two? For example, item A in the ROI template would be the total number of patients enrolled and item B would be the breakdown of the patient population by payer.

A: It is not expected that Medicare and Dual Eligible patients will be separated, however, a more granular breakdown would provide more information for the review committee to consider.

Q: Can you clarify what is meant by ineligible expense item of "expense that are primarily for marketing purposes"? Does this refer to expenses that are primarily for marketing purposes for the hospital? Or marketing any aspect of the regional partnership efforts? We see the potential need to develop marketing materials for the community care team intervention.

A: This was borrowed from the Community Benefit report and intended so that dollars were not eligible if they were primarily to market the hospital in a manner to increase volume or profitability.

Q: Can you clarify the exception of the chronic care management fee from the "most billable expenses" ineligible expense item? Does this mean that implementation funding could be used to cover the patient's co-payment or co-insurance to participate in a CCM program or is it only for support needed to enable the practice to bill for CCM?

A: The primary intent was to permit hospitals to provide needed support to enable a physician practice to bill for CCM. Of course, however these dollars are used, it must be done in compliance with State and Federal law. If one is considering using dollars to cover patients' co-payment or co-insurance to participate in a CCM program, it is recommended that you seek legal advice to ensure that it does not violate and State or Federal Law.

Q: Can you please clarify the level of detail that is expected for the implementation plan? If a particular strategy within a larger intervention is to be launched by a particular person, will it be enough to include a start and end date (start=planning, and end=launch) to that initiative, and assign a point person - or do you expect us to describe the various steps that person will have to take to launch the initiative?

A: Item #7 under the narrative requirements requires an implementation work plan using project management software. Each relevant element of an initiative should be titled and timing should be charted in the section. So the various steps the individual(s) will need to take would be helpful in this section.

Q: If a hospital is awarded a grant, how will the grant funding be implemented in the hospital's rate order? Will the grant award be marked up so that after the hospital bills and generates the funding, the grant funding collected will equal the grant funding awarded? (e.g. if the grant award was $3M, the amount put into the rate order would be $3M plus hospital mark-up)

A: The grant amount will be marked up in rates. So, in the example, the amount put in rates for a $3M grant would be $3 million plus the hospital markup.

Q: Two hospitals are doing joint work on several initiatives. Monies flow through to each individual hospital then out to support the initiatives. In annual reporting moving forward, is the reporting, particularly the use of grant dollars, supposed to be filed with the HSCRC at a hospital level or at the Grant application level - for us the Bay Area Transformation Project?

A: The HSCRC will continue the GBR infrastructure reports on an annual basis. Those GBR reports are hospital specific. However, we are anticipating adding a schedule to the GBR reports for those hospitals who have received transformation implementation grant dollars that could be viewed on a multiple hospital basis.

Q: I have a question on the expectation for #10 regarding the summary. It states that one summary table is required for each intervention. We have three interventions but they have many of the similar measures, financials, etc. Do I do a complete Appendix C chart for each intervention with most of the same information or do I break down the three intervention pieces under #2 section and just do one Appendix C chart?

A: In the proposal summary in Appendix C, please use one chart. If there are multiple interventions, please delineate each intervention separately. So for example, in the first box under target population, identify the target population for each intervention by showing it in 1., 2., 3. order. In the subsequent boxes respond to each question in the same sequential order (1., 2., 3., etc.) so that the reviewers may identify the answers for each intervention.