REQUEST FOR PROPOSALS

REGIONAL PARTNERSHIPS FOR HEALTH SYSTEM TRANSFORMATION

***Grant name*:**	**Regional Partnerships for Health System Transformation**
***Released by*:**	**Maryland Health Services Cost Review Commission (HSCRC) and Maryland Department of Health and Mental Hygiene (DHMH)**
Release date:	**February 10, 2015**
Applications due:	**April 15, 2015**

Overview

The Maryland Department of Health and Mental Hygiene (DHMH) and Health Services Cost Review Commission (HSCRC) seek proposals for funding to support the planning and development of *Regional Partnerships for Health System Transformation* in support Maryland's new 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 allows 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 will require increased collaboration between health systems, payers, community hospitals, ambulatory physician practices, long-term care, and other providers, as well as public health and community-based organizations. It will also require effective engagement of patients and consumers.

In order to accelerate effective implementation, Maryland needs to develop regional partnerships that can collaborate on analytics, target services based on patient and population needs, and plan and develop care coordination and population health improvement approaches. We are inviting and supporting the development of partnerships capable of identifying and addressing their regional needs

and priorities and shaping the future of health care in Maryland. This should include developing care coordination and population health priorities, determining what resources are needed and available, and how resources and strategies should be deployed.

Background

The state of Maryland is leading a transformative effort to improve care and lower the growth in health care spending through Maryland's new All-Payer Model. Effective January 1, 2014, Maryland and CMMI entered into a new initiative to modernize Maryland's unique rate-setting system for hospital services. This initiative, replacing Maryland's 36-year-old Medicare waiver, aims to transform Maryland's health care system to enhance patient care, improve population health, and lower total costs. Under the All-Payer Model, Maryland has committed to meeting the following key requirements:

Cost Requirements

- The all-payer per capita total hospital revenue growth will be limited to 3.58% per year over the five years (plus an adjustment for population growth), which is the 10-year compound annual growth rate in per capita gross state product ("GSP"). This cap could be adjusted in years four and five based on more recent GSP trending.

- Medicare per beneficiary total hospital cost growth over five years shall be at least $330 million less than the national Medicare per capita total hospital cost growth over five years. This is estimated to represent a savings level of about one-half percent per year under the national Medicare spending growth rate beginning in year two of the model.

Quality Requirements

- Maryland will achieve a number of quality targets designed to promote better care, better health, and lower costs. Under the model, the quality of care for Maryland residents, including Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries, will improve as measured by hospital quality and population health measures.

- Specific requirements of the model to improve quality include:

- The aggregate Medicare 30-day unadjusted all-cause, all-site readmission rate will be reduced to the corresponding national rate over five years.

- An annual aggregate reduction of 6.89% in Potentially Preventable Conditions (PPCs) over five years will result in a cumulative reduction of 30% in PPCs over the life of the model.

HSCRC formed an Advisory Council and several workgroups to offer advice and guidance to support the successful implementation of this comprehensive and complex initiative. The Advisory Council indicated that HSCRC should work with providers, payers, and consumers to analyze data to identify opportunities to improve patient care and health outcomes. In particular, health care providers and other organizations should identify patients (using secure and confidential approaches to data access and management) with complex medical needs and chronic conditions who are frequent users of the health care system and carefully target care coordination and health improvement activities to patients in need.

Moving forward, 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, and community health workers, can 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 is operating 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; establish Health Enterprise Zones; and enroll individuals in health coverage.

While changes to hospital payment mechanisms consistent with the new model are well underway, additional work is 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. This funding opportunity, which was established in the Budget Reconciliation and Financing Act (BRFA) of 2014, will fund the development of multi-stakeholder health system transformation partnerships in five or more regions.

Application Process

DHMH and HSCRC will provide a maximum of $400,000 for each approved application. The application process will be competitive, with five or more awards being made in the state. Some areas of the state may require more time to prepare for this undertaking or may benefit from joining forces with other applicants. Funding will be allocated via HSCRC-approved rate increases for hospitals participating in partnerships that receive awards. For this reason, the application should be submitted by a hospital in consultation with partner organizations. Individual applicant partners may be included in more than one application due to the nature of the process.

Applications must be submitted by the date below to dhmh.pophealth@maryland.gov. A multi-stakeholder committee, established in accordance with the BRFA, will review the applications. Funding guidelines and priorities, listed on page 6, will be used by the committee to recommend funding decisions. Lessons learned during this process may inform future opportunities to expand efforts to areas of the state that are not yet prepared to undertake this process.

Application Timeline

- Funding announcement: February 10, 2015
- Application deadline: April 15, 2015
- Anticipated award announcement: May 1, 2015

Technical Assistance

During the application process, questions and answers will be posted on the HSCRC website. Additional questions may be submitted to the individuals listed on page 9. In addition, DHMH and HSCRC will make a package of technical assistance available to awardees. The technical assistance package will include utilization data and information on existing evidence-based models that may be used during the planning process, as well as expert advice and consultation. Data elements to be provided include, but are not limited to Descriptive tables for the subject area concerning 2013 utilization of hospitals, ERs, SNFs by Medicare beneficiaries; description of the number of FFS Medicare beneficiaries and sub-sets by diagnosis, age, residence; readmissions and Hospital Acquired Conditions for Medicare; and Census data.

Application Requirements

- **Scope and Need** (1-3 pages). 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, which must encompass at least 250,000 Marylanders. Additionally, data and a corresponding narrative should be used to describe the health need(s) and condition(s) that the delivery model would address within the proposed geographic area. Applicants are strongly encouraged to utilize existing Community Health Needs Assessments (CHNAs) or other related documents to describe the health need. Applicants are also encouraged to indicate additional data and technical support that could help in undertaking this effort. DHMH and HSCRC, to the extent practicable, will devote a portion of the funding from each grant to obtaining this additional data and technical support.

1. **Model Concept** (3-5 pages). This section must include a description of a proposed delivery/financing model to be developed over the funding period. The description should include information on the target patient population(s), the services and/or interventions the patients would receive, and the role of each participating partner. This section should also highlight the anticipated infrastructure (e.g., analytics) and workforce that would be needed to support the model. The discussion of the model concept may be broad; the details of which will be developed over the planning period. This section should specifically describe how it will move toward meeting the goals and requirements of the new All-payer model in Maryland.
2. **Population Health Strategy** (2-3 pages). While the model concept itself should focus on particular patient populations (e.g., patients with multiple chronic conditions and high resource use, frail elders with support requirements, dual-eligibles with high resource needs), the proposal should also include a strategy for improving overall population health in the region over the long-term, with particular attention paid to reducing risk factors. This population health strategy should incorporate and build upon those existing population health action plans developed by Local Health Improvement Coalitions (LHICs) together with CHNAs, along with expansion to address chronic conditions and frail elders, and other specific resource needs relevant to aging populations that are proven or expected to move Maryland toward meeting the goals and requirements of the All-Payer Model.
3. **Potential for Sustainability** (3-5 pages). This section should include a proposed financing mechanism that would sustain the model, such as devoted community benefits dollars, hospital

savings, or other mechanisms. Again, the discussion of potential financial mechanisms may be broad. The partners should demonstrate a commitment to sharing resources and addressing alignment of payment models on an ongoing basis.

4. **Proposed Process and List of Partners** (1-3 pages). This section should include a description of the proposed planning process and a list of the participating entities. For example, a description of the process may include the number of meetings that will be held, the analytic work that is needed for planning, and decision-making on model design and financial mechanisms, the role of any consultants, etc.
5. **Budget Narrative** (3-5 pages). Applicants may request a funding amount not to exceed $400,000. This section should include a line item budget and a brief narrative justifying the expenses. Funds should be used for planning activities, convening key partners, developing concepts and measures to test change, data analytics, and developing of the final plan.

Funding Guidelines

Adoption of a proposal shall be based entirely on the merit of the proposal and its potential to work toward the goals and requirements of the new All-Payer Model so long as the following requirements are met. All proposals must:

- support the purpose of All Payer Model of hospital payment, which is achievement of the three-part aim: improved outcomes, lower costs, and enhanced patient experience;
- be scalable as the partnerships demonstrate success;
- support coordinated action in areas where uncoordinated action could lead to additional cost and confusion;
- have the support of the LHIC(s) in the region; and
- help to align other parts of the health care system with the goals of the All-Payer Model.

Model Priorities

While all complete applications meeting the funding guidelines above will be accepted and reviewed, priority for funding will be given to applications proposing models that include the following characteristics/features:

1. **A comprehensive, diverse set of partners with standing in the region.** The application should ideally present a partnership that includes at least the main hospital(s) and their affiliated providers, independent ambulatory physicians and practitioners, and home care and facility-based providers. Additional priority will be given to partnerships that include mental health and substance abuse services, aging services, local health departments, and local civic leaders. Because of the laws and authorities of HSCRC, the grant will be provide to a hospital, which will be accountable for dispersing funds to partners which may include a not-for-profit or public lead organization. The application should show that arrangements for financial management are in place and that they are in accord with the roles articulated in the proposal. The partnership should also demonstrate the ability to test hypotheses, generate and work with data, generate defensible decisions, and be seen as valuable in the community.

2. **Multiple target high-cost conditions/populations, with initial focus on Medicare.** A key focus of the new All-Payer model is better chronic care and improved care coordination for high needs patients. An analysis of the HSCRC hospital data suggests that two-thirds of patients with high and recurring resource use are Medicare patients. Fifteen percent of Medicare patients with 6 or more chronic conditions account for fifty percent of Medicare's health care costs. Some of these high needs individuals are also covered by Medicaid. Models with larger scale that address multiple high-cost conditions (e.g., "high-utilizers" with frailty (functional disability associated with advanced age), substance abuse, serious mental illness, ESRD, diabetes, cardiovascular disease, COPD, etc.) in these populations will, in general, have greater likelihood for meeting the three-part aim and move toward meeting the goals and requirements the All-Payer Model. For this reason, it is preferred for each partnership's early efforts to focus on Medicare and/or dual eligible beneficiaries at a minimum. Over the long-term, the model should be scalable to include patients covered by Medicaid, private insurers, and other payers.

3. **Integrating primary care, prevention, and addressing multiple determinants of health.** Disease management and care coordination activities for high-cost conditions are perhaps the quickest way to generate savings. However, sustained savings over the long-term depends on addressing the full set of determinants that drive health in order to prevent at-risk patients from becoming high utilizers. Models that include integration with advanced primary care (e.g., patient centered medical homes); interventions to address patients' non-medical needs,

such as transportation, housing, and social needs; improvements in care planning and interoperability of care plans; and evidence-based strategies for improving overall population health will receive priority. These types of activities should involve the LHIC(s) and partners like the local health department, community-based organizations, Area Agencies on Aging, etc.

4. **Sustainability concept that builds on the All Payer Model and other delivery/financing models.** Applications that propose innovative, value-based financial arrangements that build on the All Payer Model, ACOs, and other delivery models and reinvest hospital savings generated in the short-term into long-term, sustainable funding will receive priority. Examples include pay for performance, physician gain-sharing, shared savings, and regional health trusts. Grant funding from the state and/or foundations or other sources will not be considered a sustainable funding source. In addition, applicants that propose innovative uses of community benefits spending will receive priority.

Required Deliverables

Two deliverables will be required of all awardees. An overview of these deliverables is presented below. More specific guidelines on what must be included in both deliverables will be released in May 2015.

1. **Interim Report.** An interim report on progress and plans will be due on September 1, 2015. This report must describe the stakeholder engagement process, including what organizations and persons have been involved in the planning process, and the decision-making process to date, including a review of data being used to inform decisions and a list of decisions made related to the delivery financing model. The report should also discuss how the coalition envisions continuing its work after the planning process is complete. Requests for technical assistance may be made in the interim report. DHMH and HSCRC may provide feedback to the awardee based on the interim report.

2. **Regional Transformation Plan**. The final deliverable for awardees is the Regional Transformation Plan, which must be submitted to HSCRC and DHMH no later than December 1, 2015. Earlier submission of the plan is encouraged. This plan will include a detailed description of the delivery and financing model, details on the infrastructure and staffing/workforce needed to support the model, and target outcomes for lowering utilization/costs and improving population health.

It should be anticipated that the partnership will be accountable for implementation of its Regional Transformation Plan. Partnership participants should be comfortable in directing and investing in implementation of the Plan and insisting on utilization/cost and population health outcomes.

Contact Information

Questions about this funding opportunity should be directed to:

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