FAQs – HSCRC Transformation Implementation Program RFP

Updated December 14, 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.

Q: I have provided an example and in a column, I have listed our questions. Can you reply to us or in the Q/A section of the HSCRC website? Thank you for your guidance.

C. Annual Intervention Cost/Patient		**Question: is this to include overhead costs too?**
F. Annual Gross Savings (XX% x E)		**Can we use numbers from CRISP instead of percentage?**

G. Variable Savings (F x 50%)		does this include collection costs?

A: C. It would include overhead costs.

D. Justified dollar amounts may be used.

G. Yes, it includes collection costs.

Q: We are attempting to pull the Core Outcome Data from Appendix A of the application but we are having difficulty finding the source data. Several of the sources refer to HSCRC reports but we are not clear as to which reports contain the required data. Any help would be appreciated.

A: During the first week of December, CRISP will provide a zip code level file with counts/summaries of total charges, bedded care visits, ED visits, IP eligible discharges, IP readmissions, and total PAU charges. These counts will be available for several populations: all payer, Medicare FFS (primary expected payer), race and ethnicity categories, individuals with 2+ chronic conditions and Medicare, high utilizers – all payer, and high utilizers – Medicare. This file will provide hospitals with data for planning and preliminary core outcomes development.

Q: What is the timeframe needed for the data requested in Appendix A Table 1 and Table 2?

A: We would expect to see baseline and projected measures for Calendar Years. The baseline should be the most recent Calendar Year available, and the projections should be each year following the baseline year.

Q: 1) With the RFP deadline moved to Dec 21, 2015, and the announcement of awards moved to the end of February, how does that impact the 'year' for budget / funding, metric performance and ROI? Is it now a 10 month year? Or will we use a 12 month period beginning 3/1/16?

2) Because the other Plans (hospital-specific and Final Plan) are still due December 7th, is HSCRC expecting hospitals to implement plans January 1st without knowing whether they are getting funding?

A: 1) Use a Calendar Year period.

2) The strategic plan is much broader and should identify the overall strategic plan under which the proposed implementation grant intervention would be one intervention within that larger strategic plan. So you may assume that the initiative that you are proposing for Transformation Implementation Grant funding becomes operational in your larger Strategic Plan.

Q: Does the extension to the submission deadline for the Transformations RFP apply to individual hospitals applying for the .25% (as well as to coalitions applying for the .50%)?

A: The extension applies to all hospitals applying for HSCRC Transformation Implementation Program Grants.

Q: We recently received data to help populate the core measures in Appendix A. Can you help answer the following about the data set that was sent out?

- **What is the difference between Charges and Total PAU Charges?**
- **What type of visits are included in the Visits column?**
- **What does Eligible for Readmit mean?**
- **Are dual-eligibles included in this dataset?**

A: Answers are below:

- Total Charges = Total inpatient and outpatient hospital charges
- Total PAU Charges = Total charges for potentially avoidable utilization (readmissions, PQIs, complications)
- Visits = all IP and OP hospital visits
- Eligible for Readmit = those cases that quality for a readmission based on HSCRC logic (e.g., deaths and newborns removed)
- Dual eligible were included in this analysis

Q: The timing of the February grant award announcement has an impact on both the budget and interventions an RP can perform, as follows:

- **There is a lead-time of 2-3 months to hire resources for several planned interventions, resulting in a May/June start date.**
- **With some interventions starting in May/June, this impacts our ability to realize a full years' worth of interventions in 8 to 9 months, which impacts ROI.**

What advice does HSCRC have regarding performance expectations (including ROI) and funding based upon the shortened year in 2016?

A: Please show expected performance for the Calendar Year 2016, even though it may be 8 to 9 months. It would be helpful to calculate it on an annualized basis as well. For out years, please show on a Calendar Year basis.