maryland
health services
cost review commission

Regional Partnership Catalyst Grant Program
Scale Target Frequently Asked Questions (FAQs)
February 2021

The Regional Partnership Catalyst Grant program includes scale targets to help identify the impact of funded activities. Scale targets are predetermined process and outcome goals set by HSCRC staff for the diabetes and behavioral health crisis services funding streams. These targets are designed to be applied throughout the duration of the grant period. Regional Partnerships that are awarded funds are responsible for achieving the scale targets as a condition of continued grant funding.

Several questions have been received about how the scale targets are calculated. The following list includes the most frequently asked questions.

Overview of Scale Targets

1. **Where can our Regional Partnership get information about the annual scale targets that are required for diabetes and behavioral health crisis services?**

   The final scale target details can be found in the attached appendices.

ACS vs. Census Data

1. **Do the Scale Targets include children?**

   The initial population included in the Scale Target Workbooks were individuals under the age of 18. Starting in November 2020, the workbooks were updated to exclude individuals under the age of 18, therefore the Scale Targets exclude children.

2. **What is the rationale for not scaling by payer share or the mix of patients in a service area?**

   The population denominator takes the adult ACS population from the service area zip codes and applies a prediabetes prevalence rate of 10.5 percent. Regional Partnerships are funded through an all-payer rate setting and thus the impact is not intended to be limited to only Medicare/Medicaid. The Scale targets are set to indicate an intended growth trajectory, Regional Partnerships should not limit their scope or outreach to meeting just these numbers.

Annual targets

1. **Which patients are included in Scale Targets?**

   Scale Targets include all Medicare patients, residing in any zip code, with an outpatient, emergency department, observation, or inpatient claim at any of the partner hospitals, with an ICD-10 diabetes code in any position

2. **How are out-of-state patients handled?**

   We are not removing out-of-state patients from measures that are based on casemix data. For Medicare only data/targets, this is limited to Maryland residents since that is the extent of our data access.

3. **Are patients double-counted across regional partnerships? For example, if someone resides in Western Maryland and has an outpatient or ED claim at a hospital in Western Maryland but comes to one of our Baltimore City hospitals for tertiary care and has a diabetes code on their IP claim -- are they counted in both denominators?**

   Yes, they will be double counted in this scenario.The patient may be double counted across Regional Partnership programs but not double counted within the same hospital.

COVID-19 Implications

1. **What are the implications of COVID-19 on calculating Scale Targets?**

   The HSCRC staff understand the unprecedented nature of the COVID-19 pandemic. Because scale targets are not formally evaluated until the end of the grant performance year, HSCRC staff will evaluate later in 2021 the need to modify scale targets. Further guidance will be issued at the end of 2021 on this topic.

Appendix A – Scale Targets Diabetes Prevention Program

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

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

Table 1. Expected Statewide National DPP Progression[1]

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

Overall Methodology:

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

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

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

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

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

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

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

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

Appendix B – Scale Targets Diabetes Management

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

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

Overall Methodology:

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

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

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

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

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

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

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

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

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

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

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

Appendix C – Scale Targets Behavioral Health Crisis Services

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

Overall Methodology:

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

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

Crisis Services Scale Targets – Years 1-5

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

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

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